

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10311

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10311

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>WORCESTER</b><br><b>BALTIMORE</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution) Residence before admission)<br>a. STATE <b>506 Cedarcroft Rd</b><br><b>BALTIMORE</b> MD <b>12</b> ✓ |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE</b> OCEAN CITY   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE</b> MD <b>30.4</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Ocean Park Motel Ocean City, Maryland</b>  |  | d. STREET ADDRESS<br><b>506 Cedarcroft Road</b>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>ROSE</b> First <b>May</b> Middle <b>Barlow</b> Last  |  | 4. DATE OF DEATH<br><b>7/20</b> Month <b>1967</b> Year  |   |
| 5. SEX<br><b>F</b>  | 6. COLOR OR RACE<br><b>W</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>11/3/07</b>  |
| 9. AGE (In years last birthday) <b>59</b> yrs.  |  | IF UNDER 1 YEAR Months Days Hours Min.<br>IF UNDER 24 HRS.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>BALT.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>J. Wm. Brooks</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Laura Brown Brooks</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>  |  | 16. SOCIAL SECURITY NO.<br><b>218-16-1510</b>   |   |
| 17. INFORMANT<br><b>Husband</b>   |  | Address<br><b>Same</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOVASCULAR Collapse</b><br><b>4301</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial Infarction</b><br>(c) <b>Anterior &amp; Posterior Cardiovascular Disease</b> <b>Three Years</b>                             |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Three Years</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>NO</b>  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |   |
| ACTUAL SIGNATURE<br><b>J. Donald Capira</b> M.D.  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |
| EXAMINER'S NAME (Type)<br><b>J. DONALD CAPIRA MD</b>  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>7/24/1967</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto Maryland</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>Eugenia K. Seitz 5209 York Road</b><br><b>Seitz Funeral Home Balto. Md. 21212</b>  |  | 25a. REC'D BY REGISTRAR<br><b>JUL 25 1967</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  | 22. DATE SIGNED<br><b>July 21 1967</b>  |   |

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1950-1951

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(7-24-51)

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27-10-29

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1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

10312

## CERTIFICATE OF DEATH

10312

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Worcester</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>30.4</u>                     |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Ocean City</u>  |  | c. LENGTH OF STAY in lb<br><u>a. 7</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>16th St. + Philadelphia Ave.</u>  |  | d. STREET ADDRESS<br><u>3623 ROBERTS PLACE</u>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>GEORGE</u> Middle <u>JOHN</u> Last <u>BENZING</u>   |  | 4. DATE OF DEATH<br>Month <u>JULY</u> Day <u>17</u> Year <u>1967</u>  |   |
| 5. SEX<br><u>MALE</u>  | 6. COLOR OR RACE<br><u>WHITE</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>AUG 22 1900</u>  |
| 9. AGE (In years last birthday)<br><u>66</u> yrs.  |  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>BETH STEEL</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>STEEL</u>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>BALTIMORE, MD.</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA.</u>   |   |
| 13. FATHER'S NAME<br><u>GEORGE BENZING</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>CATHERINE FELDBAUM</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)   |  | 16. SOCIAL SECURITY NO.<br><u>213-07-2011</u>   |   |
| 17. INFORMANT<br><u>ELIZABETH STIEMLY</u>  |  | Address <u>8431 RAVENHUGH RD. BALT. 22, MD.</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio-Pulm. arrest</u><br>DUE TO (b) <u>Prob. Myocardial Infarct</u><br>DUE TO (c) <u>Arteriosclerotic Cardio-Vascular Dis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>Minutes</u><br><u>10 Years</u>                             |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>No</u>   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. <u>  </u> p.m. <u>19</u>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>TERMINALLY</u> to <u>  </u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>7-17</u> 19 <u>67</u> , and that death occurred at <u>11:30 P</u> M, from causes and on the date stated above.   |  |   |   |
| 22a. SIGNATURE<br><u>Philip P. Brous</u>   |  | 22b. DATE SIGNED  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>PHILIP P. BROUS</u>   |  | 22d. ADDRESS<br><u>1601 PHILADELPHIA AVE. Ocean City</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   | 23b. DATE THEREOF<br><u>7-20-67</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>SACRED HEART CEM.</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>7401 GERMAN HILL RD. BA. CO., MD.</u>         |
| 24. FUNERAL DIRECTOR<br><u>Charles A. Jule</u>   |  | 25. REC'D BY REGISTRAR<br><u>JUL 21 1967</u>  |   |
| ADDRESS<br><u>901 S. CONKLING ST. BALTO., 21224, MD.</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Jule</u>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

READ TO YOURSELF

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10313

CERTIFICATE OF DEATH

10313

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Worcester</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u>                     |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>807-2nd St.</u>  |   | d. STREET ADDRESS <u>807-2nd St.</u>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>John</u> Middle <u>Henry</u> Last <u>Brown</u>   |   | 4. DATE OF DEATH<br>Month <u>July</u> Day <u>8</u> Year <u>1967</u>   |   |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>Negro</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb. 11, 1888</u>   |
| 9. AGE (In years last birthday) <u>79</u> yrs.   |   | 10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>10</u> Hours <u>15</u> Min. <u>00</u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>N.C.</u>   |   |
| 11. BIRTHPLACE (County & State, or foreign country) <u>N.C.</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>  |   |
| 13. FATHER'S NAME <u>Unknown</u>   |   | 14. MOTHER'S MAIDEN NAME <u>Georgie Ella ?</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>   |   | 16. SOCIAL SECURITY NO. <u>240-05-7720</u>  |   |
| 17. INFORMANT <u>Lottie Baguell</u>  |   | Address <u>Pocomoke City, Md.</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure.</u><br>DUE TO <u>4201</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Coronary Arterial Sclerosis</u><br>DUE TO <u>3-4 YRS</u><br>(c) _____ |   |   | INTERVAL BETWEEN ONSET AND DEATH <u>3-4 YRS</u>                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>o.m.</u> p.m. <u>19</u>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>4/18</u> , 19 <u>63</u> , to <u>7/8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/8</u> , 19 <u>67</u> , and that death occurred at <u>11:30</u> A.M. from causes and on the date stated above.  |   |   |   |
| 22a. SIGNATURE <u>Neville A. Baron</u>   |   | 22b. DATE SIGNED <u>7/10/67</u>   |   |
| 22c. PHYSICIAN'S NAME (Type) <u>NEVILLE A. BARON</u>   |   | 22d. ADDRESS <u>Pocomoke, Md.</u>   |   |
| 23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>   | 23b. DATE THEREOF <u>7-12-67</u>  | 23c. NAME OF CEMETERY OR CREMATORY <u>Tindley Chapel Cem.</u>   | 23d. LOCATION (City or Town) (County) (State) <u>Pocomoke Wor. Md.</u>              |
| 24. FUNERAL DIRECTOR <u>Samuel Sauer</u>   |   | 25a. REC'D BY REGISTRAR <u>Charles Judge</u>  |   |
| ADDRESS <u>New Church, Va.</u>   |   | DATE <u>JUL 14 1967</u>   |   |

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The following is a list of the names of the persons who have been  
 named in the report of the Committee on the subject of the  
 proposed amendment to the Constitution of the State of New York.  
 The names are given in the order in which they were named in the  
 report, and are not necessarily in the order in which they were  
 named in the original report. The names are given in the order in  
 which they were named in the original report, and are not necessarily  
 in the order in which they were named in the original report.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #8 Film #G391 8/2/67 ph

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10314

10314

|  |                              |  |                                       |
|--|------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Worcester</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Ocean City</b><br>c. LENGTH OF STAY IN 1b<br><b>2 months</b>  |                              | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Chincoteague</b> b. COUNTY <b>Maryland</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Chincoteague</b> |                                       |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>1001 Phila. Ave. Ocean City, Md</b>   |                              | d. STREET ADDRESS<br><b>103 Smith Street</b>   |                                       |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Clarence W. Carpenter</b>   |                              | 4. DATE OF DEATH<br><b>July 26 1967</b>  |                                       |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>Feb 8 1899</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Fisherman</b>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY  |                                       |
| 11. BIRTHPLACE (State or foreign country)<br><b>Chincoteague</b>   |                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                       |
| 13. FATHER'S NAME<br><b>William Carpenter</b>  |                              | 14. MOTHER'S MAIDEN NAME<br><b>Nancy Williams</b>  |                                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                              | 16. SOCIAL SECURITY NO.<br><b>?</b>  |                                       |
| 17. INFORMANT<br><b>Wife</b>   |                              | Address  |                                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiovascular Collapse</b><br>DUE TO <b>Myocardial Infarction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardiovascular Disease</b><br>(c) <b>None</b>   |                              | INTERVAL BETWEEN ONSET AND DEATH<br><b>mins</b><br><b>mins</b><br><b>years</b>   |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>None</b>  |                              |  |                                       |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)   |                                       |
| 20c. TIME OF INJURY Month, Day, Year<br><b>8:31 p.m. 1967</b>  |                              | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                              | 20f. (City or town) (County) (State)   |                                       |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                              |  |                                       |
| ACTUAL SIGNATURE<br><b>J. Donald Capra</b><br>EXAMINER'S NAME (Type)   |                              | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>Address (Street, city, town, or county)  |                                       |
| 22. DATE SIGNED<br><b>7/26/67</b>  |                              |  |                                       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                              | 23b. DATE THEREOF<br><b>7-30-67</b>  |                                       |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Daisey Cemetery</b>   |                              | 23d. LOCATION (City or Town) (County) (State)<br><b>Chincoteague, Virginia</b>   |                                       |
| 24. FUNERAL DIRECTOR<br><b>Salyer Funeral Home, Chincoteague, Virginia</b>   |                              | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 31 1967</b>   |                                       |
| 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |                              |  |                                       |

1911

Dear Sir,  
I have the honor to acknowledge the receipt of your letter of the 14th inst. in relation to the above matter.  
The same has been forwarded to the proper authorities for their consideration.  
Very respectfully,  
J. H. [Name]  
[Title]

Very truly yours,  
J. H. [Name]  
[Title]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

10315

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10315

|   |                              |   |   |   |  |   |  |
|---|------------------------------|---|---|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Worcester</u> MARYLAND  |                              |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Ocean City</u>   |                              | c. LENGTH OF STAY IN 1b<br><u>1 day</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>District Hgts. - Md</u>                              |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Hamilton Hotel</u>   |                              |   |   | d. STREET ADDRESS<br><u>7322 District Pkwy</u>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Ellen</u> Middle <u>Olli</u> Last <u>Castle</u>   |                              |   |   | 4. DATE OF DEATH<br>Month <u>July</u> Day <u>26</u> Year <u>1967</u>  |  |   |  |
| 5. SEX<br><u>F</u>  | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Oct 11, 1918</u> | 9. AGE (In years last birthday)<br><u>48</u> yrs.   | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>usgout</u>  |   | 11. BIRTHPLACE (State or foreign country)<br><u>Palace Colorado</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>HERMAN Olli</u>   |                              |   |   | 14. MOTHER'S MARRIED NAME<br><u>Mildred Olli</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>NO</u>   |                              | 16. SOCIAL SECURITY NO.<br><u>  </u>  |   | 17. INFORMANT<br><u>Eugene Castle (Husband)</u> Address <u>Same</u>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>322.0</u> DUE TO <u>PRIMARIA</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ethylism, Acute</u><br>(c) <u>  </u>  |                              |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>Unknown</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                              |   |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>  |                              | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                              |   |   |   |  |   |  |
| ACTUAL SIGNATURE<br><u>F.J. Rowinsen, Jr.</u>   |                              | EXAMINER'S NAME (Type)<br><u>F.J. Rowinsen, Jr.</u>   |   | M.D.<br><u>Ocean City, Md</u>   |  | 22. DATE SIGNED<br><u>July 26, 1967</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |                              | 23b. DATE THEREOF<br><u>7/29/67</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>CEDAR HILL CEMETERY</u>  |  | 23d. LOCATION (City or Town) (County) (State)<br><u>SUITLAND, PRINCE GEORGES, Md.</u>             |  |
| 24. FUNERAL DIRECTOR<br><u>ROBERT E. WILHELM FUNERAL HOME</u><br><u>4308 SUITLAND ROAD, SUITLAND, MARYLAND</u>  |                              |   |   | 25a. REC'D BY REGISTRAR<br><u>JUL 31 1967</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles J. J...</u>  |  |

1000

Handwritten notes and signatures at the top of the page, including a signature that appears to be "J. H. [illegible]".

Main body of handwritten text, consisting of several lines of cursive script, likely a letter or report.

Bottom section of the page containing additional handwritten notes and a signature.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10316

10316

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |                              |   |   |   |   |   |   |
|---|------------------------------|---|---|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>WORCESTER</u> MARYLAND  |                              |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>VIRGINIA</u> b. COUNTY <u>ACCOMACK</u> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>OCEAN CITY</u>   |                              |   |   | c. LENGTH OF STAY IN 1b<br><u>3 WKS</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>KELLER</u> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>OCEAN, FOOT OF 7TH AVE.</u>  |                              |   |   | d. STREET ADDRESS<br><u>PO BOX: KELLER, VA</u>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>RONNIE</u> Middle <u>CONQUEST</u> Last <u>CONQUEST</u>  |                              |   |   | 4. DATE OF DEATH<br>Month <u>7</u> Day <u>3</u> Year <u>1967</u>  |   |   |   |
| 5. SEX<br><u>M</u>  | 6. COLOR OR RACE<br><u>N</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>May 27, 1952</u> |   | 9. AGE (In years last birthday)<br><u>15</u> yrs. | 10. IF UNDER 1 YEAR<br>Months <u>1</u> Days <u>3</u> Hours <u>15</u> Min.                         |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>STUDENT</u>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>#</u>   |   | 11. BIRTHPLACE (State or foreign country)<br><u>VIRGINIA</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |
| 13. FATHER'S NAME<br><u>GEORGE KELLAM HATTIE</u>  |                              |   |   | 14. MOTHER'S MAIDEN NAME<br><u>HATTIE CONQUEST</u>  |   |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>NO</u>  |                              | 16. SOCIAL SECURITY NO.<br><u>228-72-6950</u>   |   | 17. INFORMANT<br><u>CALVIN SMITH</u>  |   | Address <u>WACHAPREAGUE VIRGINIA</u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ASPHYXIA</u><br>DUE TO <u>DROWNING</u><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>PULMONARY EDEMA</u><br>(c) <u>DROWNING</u>   |                              |   |   |   |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>MINUTES</u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                              |   |   |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                              | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)<br><u>FELL OFF SURFBOARD UNABLE TO SWIM</u>                     |   |   |   |   |   |
| 20c. TIME OF INJURY<br>Hour <u>10:15</u> a.m. <u>7/3/67</u> p.m.  |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>BEACH</u>  |   | 20f. (City or town) (County) (State)<br><u>OCEAN CITY, WORCESTER MD</u>                           |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                              |   |   |   |   |   |   |
| ACTUAL SIGNATURE<br><u>R.F. KAPPELOWITZ</u>   |                              | M.D.  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   | 22. DATE SIGNED<br><u>7/3/67</u>  |   |
| EXAMINER'S NAME (Type)<br><u>R.F. KAPPELOWITZ</u>   |                              | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   | Address (State, city, town, or county)<br><u>Ocean City, Md</u>   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                              | 23b. DATE THEREOF<br><u>7-08-67</u>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Red Hill</u>   |   | 23d. LOCATION (City or Town) (County) (State)<br><u>Keller, Va.</u>                               |   |
| 24. FUNERAL DIRECTOR<br><u>G.C. Humbles</u>   |                              | ADDRESS<br><u>Accomack, Va.</u>   |   | 25a. REC'D BY REGISTRAR<br>DATE <u>JUL 6 1967</u>   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |

1871

Received of the  
Hon. Secy of the  
Treasury  
the sum of \$1000  
for the purchase of  
land in the  
State of Texas  
for the purpose of  
establishing a  
school for the  
benefit of the  
Indian children  
of the  
tribe of the  
State of Texas  
and for the  
purchase of  
land in the  
State of Texas  
for the purpose of  
establishing a  
school for the  
benefit of the  
Indian children  
of the  
tribe of the  
State of Texas

Witness my hand  
at Washington  
this 1st day of  
January 1871  
John A. B. Smith  
Secretary of the  
Treasury

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10317

10317

|  |  |   |  |  |  |   |   |
|--|--|---|--|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>WORCESTER</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>BALT</b>                                |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>RURAL, OCEAN CITY</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>8 HRS</b>  |  |   |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE 22</b>  |  |   |  | d. STREET ADDRESS<br><b>1404 STENGLE AVIE</b>  |  |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>FISHING BOAT</b>  |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>UPSHAW JAMES CUSTIS</b>   |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>7 1 1967</b>  |  |   |   |
| 5. SEX<br><b>M</b>   |  | 6. COLOR OR RACE<br><b>W</b>              |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>6/22/06</b>  |   |
| 9. AGE (In years lost birthday) yrs.<br><b>61</b>  |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.<br>Months Days Hours Min.   |  |   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>CUSTODIAN</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>JANITORIAL</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>POCOMOKE, MD.</b>                             |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |  |  |   |   |
| 13. FATHER'S NAME<br><b>JAMES M. CUSTIS</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>MCCREANY JUSTIS</b>   |  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>219-06-4914</b>  |  | 17. INFORMANT<br><b>JOS. A. THOMAS, 8428 KAVANAGH ST BALT, MD.</b>                            |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOVASCULAR COLLAPSE</b><br>DUE TO (b) <b>MYOCARDIAL INFARCT</b><br>DUE TO (c) <b>ARTERIO SCLEROTIC CARDIOVASC. DISEASE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br><b>SEASICKNESS</b>   |  |   |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>MINUTES</b><br><b>YEARS</b>                                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>SEASICKNESS</b>  |  |   |  |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>11</b> a.m. <b>7/1</b> 19 <b>67</b><br>p.m.  |  |   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input checked="" type="checkbox"/><br>at work at work  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>FISHING BOAT</b> |   |
| 20f. (City or town) (County) (State)<br><b>OCEAN CITY WORCESTER, MD</b>  |  |   |  |  |  |   |   |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |  |  |   |   |
| ACTUAL SIGNATURE<br><b>R.F. KAPTELOWITZ</b>  |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |   |
| EXAMINER'S NAME (Type)<br><b>R.F. KAPTELOWITZ</b>  |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |   |
|  |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |   |   |
|  |  |   |  | Address (Street, city, town, or county)<br><b>POCOMOKE CITY, MD</b>  |  |   |   |
| 22. BURIAL, CREMATION, or REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE THEREOF<br><b>7-4-1967</b>      |  | 23c. NAME OF CEMETERY<br><b>NELSON CEMETERY</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>ACCOMACK COUNTY, VIRGINIA</b>             |   |
| 24. FUNERAL DIRECTOR<br><b>Robert H. Watson</b>  |  |   |  | 25a. REC'D BY REGISTRAR<br><b>JUL 5 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Robert H. Watson</b>   |   |

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10318

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Worcester</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>WOR</u>                         |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Whiteville</u>  |  | c. LENGTH OF STAY IN 1b <u>35 years</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RI Box 246</u>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print) <u>HARRY BRYON DAVIS</u>  |  | 4. DATE OF DEATH <u>July 21 1967</u>   |  |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>W</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov 13, 1900</u>   |
| 9. AGE (In years last birthday) <u>66</u> yrs.  |  | IF UNDER 1 YEAR Months Days  | IF UNDER 24 HRS. Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>  | 11. BIRTHPLACE (State or foreign country) <u>Williamport Md.</u>               |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  | 13. FATHER'S NAME <u>VIRGIL DAVIS</u>  |  |
| 14. MOTHER'S MAIDEN NAME <u>SARA MARGARET CLARK</u>   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>NO</u>   |  |
| 16. SOCIAL SECURITY NO. <u>217-36-0827</u>  |  | 17. INFORMANT <u>MRS DAVIS (WIFE) Whiteville, Md.</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4221</u> DUE TO <u>PULMONARY EDEMA, Acute ASCUD</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)   |  | INTERVAL BETWEEN ONSET AND DEATH <u>13 years</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)           |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <u>19</u>  | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |
| ACTUAL SIGNATURE <u>F.J. Townsend, Jr</u> M.D.  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  |
| EXAMINER'S NAME (Type) <u>F.J. Townsend, Jr</u>   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |  |
|   | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>   |  |  |
|   | Address <u>Ocean City Md</u>   |  |  |
| 22. DATE SIGNED <u>July 21, 1967</u>  |  |  |  |
| 23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>  | 23b. DATE THEREOF <u>7/23/67</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>State</u>  | 23d. LOCATION (City or town) (County) (State) <u>Whiteville Worcester, Md.</u> |
| 24. FUNERAL DIRECTOR <u>Peter Whaley Selbyville, Del.</u>   |  | 25a. REC'D BY REGISTRAR <u>JUL 25 1967</u>   |  |
| ADDRESS   |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |  |

5152

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |   |  |   |   |  |  |  |   |  |
|---|--|--|---|--|---|---|--|--|--|---|--|
| 10319 CERTIFICATE OF DEATH 10319  |  |  |   |  |   |   |  |  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Worcester</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bishopville</b><br>c. LENGTH OF STAY IN 1b <b>38 Yrs</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>xx</b> |  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Worcester</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bishopville</b><br>d. STREET ADDRESS <b>RFD</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |  |  |   |  |
| 3. NAME OF DECEASED (Type or print) <b>Katherine D. Day</b>   |  |  | 4. DATE OF DEATH <b>July 1, 1967</b>  |  | 5. SEX <b>Female</b>  |   | 6. COLOR OR RACE <b>White</b>                          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |  |
| 8. DATE OF BIRTH <b>Dec. 14, 1870</b>   |  |  | 9. AGE (in years last birthday) <b>96</b> yrs.  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>Nurse</b>         |  | 11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>  |   |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |  | 13. FATHER'S NAME <b>Unknown</b>  |  |   | 14. MOTHER'S MAIDEN NAME <b>Elizabeth Day</b>   |  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>xx</b>  |   |  |
| 16. SOCIAL SECURITY NO. <b>220-52-7971</b>  |  |  | 17. INFORMANT <b>Flora McCabe</b>   |  |   | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cremia</b><br><b>4341</b><br>DUE TO <b>Congestive Heart Failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>10 yrs</b><br>DUE TO (c) |  |  | INTERVAL BETWEEN ONSET AND DEATH   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |  |   |  |   |   |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)                   |  |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Sept</b> , 1967, to <b>July</b> , 1967, that (I) (we) last saw the deceased alive on <b>July 1, 1967</b> , and that death occurred at <b>9A</b> M, from the causes and on the date stated above.                     |  |  |   |  |   |   |  |  |  |   |  |
| 22a. SIGNATURE <b>Frank E. Gantz Jr.</b>  |  |  |   |  | 22b. DATE SIGNED <b>7/6/67</b>  |   | 22c. PHYSICIAN'S NAME (Type) <b>Frank E. Gantz Jr.</b> |  |  |   |  |
| 22d. ADDRESS <b>5 Bay St. Berkeley Md.</b>  |  |  |   |  | 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |   |  |  |  |   |  |
| 23b. DATE THEREOF <b>7/3/67</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellows</b>   |  |   | 23d. LOCATION (City, town or county) (State) <b>Bishopville, Md.</b>  |  |  |  |   |  |
| 24. FUNERAL DIRECTOR <b>Peter Whaley Selbyville, Md.</b>  |  |  |   |  | 25a. REC'D BY REGISTRAR <b>JUL 10 1967</b>  |   | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>        |  |  |   |  |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10320

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10320

|   |                                  |   |   |  |   |   |   |
|---|----------------------------------|---|---|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Worcester</b> MARYLAND  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b> ✓ |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural-Pocomoke City</b>  |                                  |   | c. LENGTH OF STAY IN b<br><b>3 days</b>           |  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Joppa 21085 12-2</b> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Pocomoke River</b>   |                                  |   |   | d. STREET ADDRESS<br><b>114 Doncaster Road</b>   |   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>MELVIN</b> Middle <b>RUSSELL</b> Last <b>DICKEY</b>  |                                  |   |   | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>10</b> Year <b>1967</b>   |   |   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 22, 1918 49 yrs.</b> |  | 9. AGE (In years lost birthday)<br><b>49 yrs.</b> | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS<br>Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Machinist</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Gas &amp; Electric Co.</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Melvin R. Dickey</b>  |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Aurinthia Adkins</b>  |   |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>Yes WW2</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>215-10-3260</b>   |   | 17. INFORMANT<br><b>Mrs. <del>Ed</del> Gladys Dickey</b>   |   | Address<br><b>(Same)</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACCIDENTAL DROWNING</b><br><b>929.8</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>NONE</b> |                                  |   |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>NONE</b>   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED <b>3</b><br>While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>RIVER</b>   |   | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>        |                                  |   |   |  |   |   |   |
| ACTUAL SIGNATURE<br><b>Robert C. LaMar</b>  |                                  | EXAMINER'S NAME (Type)<br><b>Robert C. LaMar, M.D.</b>  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   | 22. DATE SIGNED<br><b>7/13/67</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>7/17/67.</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National Cemetery</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>                                      |   |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. Baltimore, Md. 21214</b>   |                                  |   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JUL 14 1967</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |   |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME-51  
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FOR STATE  
HEALTH DEPT.

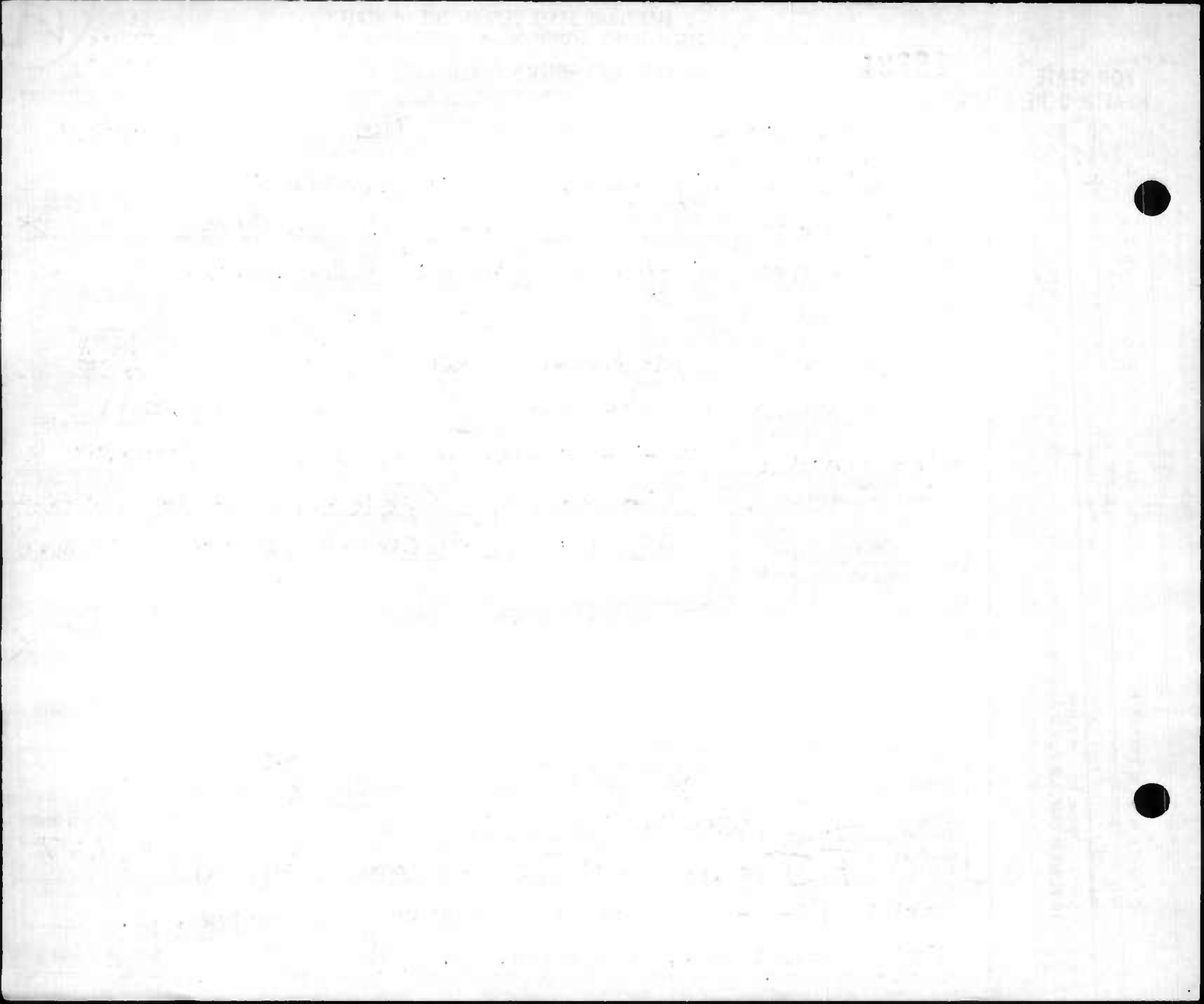
10321

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10321

|   |                           |  |                                     |
|---|---------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Worcester</u> MARYLAND  |                           | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>Washington</u>                  |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>  |                           | c. LENGTH OF STAY IN 1b <u>3 days</u>  |                                     |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>  |                           | 21-2   |                                     |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Street</u>  |                           | d. STREET ADDRESS <u>1270 Jefferson Blvd</u>   |                                     |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                           |  |                                     |
| 3. NAME OF DECEASED (Type or print) <u>JAMES</u> First <u>Richard</u> Middle <u>Dwyer</u> Last  |                           | 4. DATE OF DEATH <u>July</u> Month <u>7</u> Day <u>19</u> Year <u>67</u>   |                                     |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct 9, 1915</u> |
| 9. AGE (In years last birthday) <u>51</u> yrs.  |                           | IF UNDER 1 YEAR Months Days Hours Min  |                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Surgeon</u>  |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>Medicine</u>  |                                     |
| 11. BIRTHPLACE (State or foreign country) <u>Renovo, Penn</u>   |                           | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |                                     |
| 13. FATHER'S NAME <u>FRANK P. Dwyer</u>   |                           | 14. MOTHER'S MAIDEN NAME <u>MARY Howell</u>  |                                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WW II</u>   |                           | 16. SOCIAL SECURITY NO. <u>220-44-4554</u>   |                                     |
| 17. INFORMANT <u>Mrs. James Dwyer (wife)</u>  |                           | Address <u>Hagerstown</u>  |                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>CORONARY OCCLUSION, Acute</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD with CORONARY SCLEROSIS</u><br>(c) <u>UNKNOWN</u>   |                           | INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u>  |                                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                           | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                     |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                     |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>   |                           | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)   |                                     |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                           |  |                                     |
| ACTUAL SIGNATURE <u>F J Townsend, Jr</u> M.D.   |                           | 22. DATE SIGNED <u>July 7, 67</u>  |                                     |
| EXAMINER'S NAME (Type) <u>F J Townsend, Jr</u>  |                           | DEPUTY MEDICAL EXAMINER <u>Ocean City, Md</u>  |                                     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                           | 23b. DATE THEREOF <u>7-10-67</u>   |                                     |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>   |                           | 23d. LOCATION (City or Town) (County) (State) <u>Hagerstown, Md.</u>   |                                     |
| 24. FUNERAL DIRECTOR <u>Minnich Funeral Home, Hagerstown, Md.</u>   |                           | 25a. REC'D BY REGISTRAR <u>JUL 11 1967</u>   |                                     |
| ADDRESS   |                           | 25b. REGISTRAR'S SIGNATURE <u>Charles J. Jago</u>  |                                     |



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10322

10322

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |                           |  |  |
|---|---------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Worcester</u> MARYLAND  |                           | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Pennsylvania</u> b. COUNTY <u>Westmoreland</u>      |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>  |                           | c. LENGTH OF STAY IN 1b <u>3 days</u>  |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Kensington</u> 75.3   |                           | d. STREET ADDRESS <u>1016 PARK View Drive</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Quality Motel</u>   |                           | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) <u>HAROLD ARTHUR FARKAS</u>   |                           | 4. DATE OF DEATH <u>July 11 1967</u>   |  |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 13, 1918</u> 49 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>   |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>Food</u>  |  |
| 13. FATHER'S NAME <u>MAX FARKAS</u>   |                           | 14. MOTHER'S MAIDEN NAME <u>Rose Friedman</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>  |                           | 16. SOCIAL SECURITY NO. <u>67-07-5141</u>  |  |
| 17. INFORMANT <u>Mrs. Jeanne FARKAS, wife</u>   |                           | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>CORONARY Occlusion Acute ASCVD</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>UNKNOWN</u><br>(c)  |                           | INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>   |                           | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |                           | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                           |  |  |
| ACTUAL SIGNATURE <u>F.J. Townsend, Jr.</u> M.D.   |                           | 22. DATE SIGNED <u>July 11, 1967</u>   |  |
| EXAMINER'S NAME (Type) <u>F.J. Townsend, Jr.</u>  |                           | DEPUTY MEDICAL EXAMINER <u>James A. Burdage</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |                           | 23b. DATE THEREOF <u>7/14/67</u>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>CHERBAKADISHA</u>   |                           | 23d. LOCATION (City or town) (County) <u>LOWER BURRELL</u>   |  |
| 24. FUNERAL DIRECTOR <u>James A. Burdage</u>  |                           | 25a. REC'D BY REGISTRAR <u>JUL 13 1967</u>   |  |
| 25b. REGISTRAR'S SIGNATURE <u>James A. Burdage</u>  |                           |  |  |

0390

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

10323

10323

|   |  |   |                                  |   |                      |  |      |  |  |   |                                  |                       |                      |
|---|--|---|----------------------------------|---|----------------------|--|------|--|--|---|----------------------------------|-----------------------|----------------------|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Worcester</u> <b>MARYLAND</b>  |  |   |                                  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u>                  |                      |  |      |  |  |   |                                  |                       |                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Snow Hill</u>  |  |   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Snow Hill</u>  |                      |  |      |  |  |   |                                  |                       |                      |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>423 Covington St.</u>  |  |   |                                  | d. STREET ADDRESS<br><u>423 Covington St.</u>   |                      |  |      |  |  |   |                                  |                       |                      |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br><u>Sara H. Fisher</u>  |  |   |                                  | <b>4. DATE OF DEATH</b><br>Month <u>July</u> Day <u>27</u> Year <u>1967</u>   |                      |  |      |  |  |   |                                  |                       |                      |
| <b>5. SEX</b><br><u>Female</u>  |  | <b>6. COLOR OR RACE</b><br><u>Negro</u>                                       |                                  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                      | <b>8. DATE OF BIRTH</b><br><u>Nov. 11, 1887</u>                              |      |  |  |   |                                  |                       |                      |
| <b>9. AGE</b> (In years last birthday) <u>79</u> yrs. <table border="1"> <tr> <td>UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td>Hours</td> <td>Min.</td> </tr> </table>   |  | UNDER 1 YEAR  | IF UNDER 24 HRS.                 | Months  | Days                 | Hours  | Min. |  |  |   |                                  |                       |                      |
| UNDER 1 YEAR  | IF UNDER 24 HRS.   |   |                                  |   |                      |  |      |  |  |   |                                  |                       |                      |
| Months  | Days   |   |                                  |   |                      |  |      |  |  |   |                                  |                       |                      |
| Hours   | Min.   |   |                                  |   |                      |  |      |  |  |   |                                  |                       |                      |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Domestic</u>   |  |   |                                  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>House Work</u>   |                      | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><u>Md.</u>     |      |  |  |   |                                  |                       |                      |
| <b>13. FATHER'S NAME</b><br><u>Eric Collick</u>   |  |   |                                  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Unknown</u>   |                      |  |      |  |  |   |                                  |                       |                      |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) (If yes give year or dates of service)<br><u>No</u>   |  |   |                                  | <b>16. SOCIAL SECURITY NO.</b><br><u>213-14-1335</u>  |                      | <b>17. INFORMANT</b><br><u>Edwin Fisher</u>                                  |      |  |  |   |                                  |                       |                      |
|   |  |   |                                  | Address <u>Snow Hill, Md.</u>   |                      |  |      |  |  |   |                                  |                       |                      |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u><br>DUE TO <u>332X</u><br>Conditions, if any, which gave rise to immediate cause (b) <u>Generalized arteriosclerosis</u><br>(c), stating the underlying cause last. <u>years</u>   |  |   |                                  |   |                      |  |      |  |  |   |                                  |                       |                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH 3 days</u>  |  |   |                                  |   |                      |  |      |  |  |   |                                  |                       |                      |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |                                  |   |                      |  |      |  |  |   |                                  |                       |                      |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)<br><b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <table border="1"> <tr> <td><b>20c. TIME OF INJURY</b><br/>Hour a.m. _____ p.m. _____</td> <td><b>20d. INJURY OCCURRED</b><br/>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></td> <td><b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)</td> <td><b>20f. (City or town)</b> _____</td> <td><b>(County)</b> _____</td> <td><b>(State)</b> _____</td> </tr> </table> |  |   |                                  |   |                      |  |      | <b>20c. TIME OF INJURY</b><br>Hour a.m. _____ p.m. _____ | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) | <b>20f. (City or town)</b> _____ | <b>(County)</b> _____ | <b>(State)</b> _____ |
| <b>20c. TIME OF INJURY</b><br>Hour a.m. _____ p.m. _____  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) | <b>20f. (City or town)</b> _____ | <b>(County)</b> _____   | <b>(State)</b> _____ |  |      |  |  |   |                                  |                       |                      |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Jan. 1962</u> <b>to</b> <u>Jan. 1967</u> <b>that (I) (we) last saw the deceased alive on</b> <u>July 25, 1967</u> <b>and that death occurred at</b> <u>10 P.M.</u> <b>from the causes and on the date stated above.</b>   |  |   |                                  |   |                      |  |      |  |  |   |                                  |                       |                      |
| <b>22a. SIGNATURE</b><br><u>David Rapat</u>   |  |   |                                  | <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>            |                      | <b>22b. DATE SIGNED</b><br><u>7-28-67</u>                                    |      |  |  |   |                                  |                       |                      |
| <b>22c. PHYSICIAN'S NAME (Type)</b><br><u>DAVID RAPAT</u>   |  |   |                                  | <b>22d. ADDRESS</b><br><u>Snow Hill Md.</u>   |                      |  |      |  |  |   |                                  |                       |                      |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>Burial</u>   |  | <b>23b. DATE THEREOF</b><br><u>7-31-67</u>                                    |                                  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Coolspring Cem.</u>   |                      | <b>23d. LOCATION</b> (City, town or county) (State)<br><u>Girdletree Md.</u> |      |  |  |   |                                  |                       |                      |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>James Savage</u>  |  |   |                                  | <b>25a. REC'D BY REGISTRAR</b><br><u>Charles J. J...</u>  |                      | <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Charles J. J...</u>                  |      |  |  |   |                                  |                       |                      |
| <b>25c. ADDRESS</b><br><u>New Church, Va.</u>   |  |   |                                  | <b>DATE</b><br><u>AUG 1 1967</u>  |                      |  |      |  |  |   |                                  |                       |                      |

MEDICAL CERTIFICATION

10332

Wester

Wester

Wester

2nd Hill  
433 Grafton St.

2nd Hill  
433 Grafton St.

2nd Hill

2nd Hill

Female Negro

Female Negro

Dr. H. H. H. H.

Dr. H. H. H. H.

Eric Collick

Eric Collick

13-11-1933 Edwin Fisher 2nd Hill, Md.

13-11-1933 Edwin Fisher 2nd Hill, Md.

13-11-1933 Edwin Fisher 2nd Hill, Md.

13-11-1933 Edwin Fisher 2nd Hill, Md.

13-11-1933 Edwin Fisher 2nd Hill, Md.

13-11-1933 Edwin Fisher 2nd Hill, Md.

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13-11-1933 Edwin Fisher 2nd Hill, Md.

13-11-1933 Edwin Fisher 2nd Hill, Md.

13-11-1933 Edwin Fisher 2nd Hill, Md.

13-11-1933 Edwin Fisher 2nd Hill, Md.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10324

10324

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Worcester</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u>                       |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Ocean City</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Salisbury</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>DOA 1001 Phila Ave</u>   |  | d. STREET ADDRESS<br><u>604 Crest View</u>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>EUNICE</u> Middle <u>G</u> Last <u>IVARZ</u>  |  | 4. DATE OF DEATH<br>Month <u>July</u> Day <u>22</u> Year <u>1967</u>  |  |
| 5. SEX<br><u>F</u>  | 6. COLOR OR RACE<br><u>W</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>7-7</u>   |
| 9. AGE (In years last birthday)<br><u>77</u> yrs.   |  | IF UNDER 1 YEAR<br>Months <u>0</u> Days <u>0</u>  | IF UNDER 24 HRS.<br>Hours <u>0</u> Min. <u>0</u>                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>At Home</u>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Lithuania</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>FRANCIS Heilig</u>  |  | 14. MOTHER'S MAIDEN NAME<br><u>UNKNOWN</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)<br><u>No</u>   |  | 16. SOCIAL SECURITY NO.<br><u>UNKNOWN</u>   |  |
| 17. INFORMANT<br><u>ALAN GIVARZ (SON)</u>   |  | Address<br><u>505 Rivernew Ave Salisbury, Md.</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR Collapse - MYOCARDIAL INFARCT</u><br>4201 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>ASCVD with hypertension</u><br>DUE TO<br>(c) _____  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 years</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |
| 20f. (City or town) (County) (State)  |  |   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |
| ACTUAL SIGNATURE<br><u>RM Hughes</u>  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |
| EXAMINER'S NAME (Type)<br><u>R M Hughes, M.D.</u>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |
|   |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>  |  |
|   |  | Address (Street, city, town, or county)<br><u>Salisbury, Md.</u>  |  |
| 22. DATE SIGNED<br><u>7/22/67</u>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  | 23b. DATE THEREOF<br><u>7-24-67</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Beth Israel</u>  | 23d. LOCATION (City or town) (County) (State)<br><u>Salisbury, Md.</u> |
| 24. FUNERAL DIRECTOR<br><u>Sol Levinson &amp; Bros</u>  |  | 25. REGISTRAR'S SIGNATURE<br><u>JUL 28 1967</u>   |  |

1952

1952

1952

1952

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10326

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10325

|   |                           |   |  |  |  |   |  |
|---|---------------------------|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Worcester</b> MARYLAND  |                           |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>WOR.</b> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ocean City</b>  |                           |   |  | c. LENGTH OF STAY IN 1b <b>4 years</b>   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>9 CAROLINE ST</b>   |                           |   |  | d. STREET ADDRESS <b>9 CAROLINE ST</b>   |  |   |  |
| 3. NAME OF DECEASED (Type or print) <b>WINFIELD CARL JOHNSON</b>  |                           |   |  | 4. DATE OF DEATH <b>July 8 1967</b>  |  |   |  |
| 5. SEX <b>M</b>   | 6. COLOR OR RACE <b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>JUNE 16, 1905</b>  | 9. AGE (In years last birthday) <b>62 yrs.</b>   | IF UNDER 1 YEAR<br>Months Days Hours Min.                                      |   | IF UNDER 24 HRS<br>Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PRINTER</b>  |                           |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>PRINTING</b>  |  | 11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>                  |   | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |
| 13. FATHER'S NAME <b>John J. Johnson</b>  |                           |   | 14. MOTHER'S MAIDEN NAME <b>Josephine SWANSON</b>  |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>No</b>  |                           |   | 16. SOCIAL SECURITY NO. <b>577-12-8056</b>   |  | 17. INFORMANT <b>Mrs Dorothy Johnson, wife,</b> Address <b>Ocean City, Md.</b> |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4201 CORONARY Occlusion, Acute</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ASCVD with CORONARY &amp; MYOCARDIAL FAILURE</b><br>(c) <b>3 years</b>  |                           |   |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH <b>INSTANT</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Obesity</b>  |                           |   |  |  |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                           |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)           |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                           |   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)         |   | 20f. (City or town) (County) (State)   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                           |   |  |  |  |   |  |
| ACTUAL SIGNATURE <b>FJ Townsend, Jr</b>   |                           |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |  |   |  |
| EXAMINER'S NAME (Type) <b>FJ TOWNSEND, JR MD</b>  |                           |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |  |   |  |
|   |                           |   | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>   |  |  |   |  |
|   |                           |   | Address (Street, city, town or county) <b>Worcester County</b>   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |                           | 23b. DATE THEREOF <b>7-11-67</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>SUNSET MEMORIAL</b>  |  | 23d. LOCATION (City or town) (County) (State) <b>BERLIN, WORCESTER, MD.</b> |  |
| 24. FUNERAL DIRECTOR <b>ULLRICH FUNERAL HOME</b>  |                           |   |  | ADDRESS <b>BERLIN, MD.</b>   |  | 25a. REC'D BY REGISTRAR <b>JUL 12 1967</b>                                  |  |
|   |                           |   |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  | 22. DATE SIGNED <b>July 8, 1967.</b>  |  |

70-5518-107

LAND

Op. 242

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT

10326

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10326

|   |                           |   |   |
|---|---------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Worcester</u> MARYLAND  |                           | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>VIRGINIA</u> b. COUNTY <u>FAIRFAX</u>                  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Ocean City</u>   |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>VIENNA</u> 83.3  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |                           | d. STREET ADDRESS<br><u>8333 WESLEYAN ST.</u>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>DONALD</u> Middle <u>ELMER</u> Last <u>KRAMER</u>   |                           | 4. DATE OF DEATH<br>Month <u>7</u> Day <u>30</u> Year <u>1967</u>   |   |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>22 MARCH 1920</u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEMAN</u>  |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>VACATION HOME</u>   | 9. AGE (In years lost in job) yrs. <u>47</u>  |
| 11. BIRTHPLACE (State or foreign country)<br><u>ERIE PA.</u>  |                           | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |
| 13. FATHER'S NAME<br><u>HERMAN CRAMER</u>   |                           | 14. MOTHER'S MAIDEN NAME<br><u>EDNA MAE MILLER</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>  |                           | 16. SOCIAL SECURITY NO.<br><u>225-07-623</u>  |   |
| 17. INFORMANT<br><u>AMILIA KRAMER</u>   |                           | Address<br><u>8333 Wesleyan St. Vienna</u>  |   |
| 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>11 DROWNED IN OCEAN BEACH</u> Drowning<br>929.8<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____<br>(c) _____<br>DUE TO<br>DUE TO  |                           |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>Immed.</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>None Known</u>   |                           |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br><u>71</u>  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)<br><u>Accident</u>   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>7:30</u> <u>7-30-67</u>  |                           | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>BEACH</u>  |                           | 20f. (City or town) (County) (State)<br><u>OCEAN CITY WORCESTER, Md.</u>  |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> |                           |   |   |
| ACTUAL SIGNATURE<br><u>Philip P. Brous</u>  |                           | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |
| EXAMINER'S NAME (Type)<br><u>PHILIP P. BROUS</u>  |                           | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |
|   |                           | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |
|   |                           | Address (Street, city, town, or county)<br><u>1001 PHILADELPHIA Ave. OCEAN CITY</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Cremation</u>   |                           | 23b. DATE THEREOF<br><u>8/11/67</u>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>SILVERBROOK</u>  |                           | 23d. LOCATION (City or Town) (County) (State)<br><u>WILMINGTON DEL</u>  |   |
| 24. FUNERAL DIRECTOR<br><u>Anna A. Buehage Bulin Md</u>   |                           | 25a. REC'D BY REGISTRAR<br>DATE <u>AUG 1 1967</u>   |   |
|   |                           | 25b. REGISTRAR'S SIGNATURE<br><u>J. Charles Judge</u>   |   |

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G391 8/11/67 ph

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10327

10327

FOR STATE  
HEALTH DEPT

|  |                              |   |  |  |   |   |  |
|--|------------------------------|---|--|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Worcester</b> <b>Whaleyville, Maryland</b>   |                              |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Whaleyville, Md.</b> b. COUNTY <b>Worcester</b> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>R.F.D., Whaleyville, Md.</b>  |                              |   |  | c. LENGTH OF STAY IN 1b<br><b>88 yrs.</b>  |   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)   |                              |   |  | d. STREET ADDRESS  |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Mollie</b> Middle <b>E.</b> Last <b>Lewis</b>  |                              |   |  | 4. DATE OF DEATH<br>Month <b>7</b> Day <b>31</b> Year <b>1967</b>  |   |   |  |
| 5. SEX<br><b>F</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Dec. 16, 1879</b> |  | 9. AGE (In years last birthday)<br><b>87 88/ yrs.</b> | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Whaleyville, Md.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>David Evans</b>  |                              |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Charlotte Daisy</b>   |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |                              | 16. SOCIAL SECURITY NO.<br><b>222-182-140-D</b>   |  | 17. INFORMANT<br><b>Mrs. Ella Lewis</b>  |   | Address<br><b>Bishop, Md.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL VASCULAR ACCIDENT</b><br><b>331X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Arteriosclerosis</b><br>DUE TO (c)  |                              |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>20 hrs</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                              |   |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |  |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                              | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                              |   |  |  |   |   |  |
| ACTUAL SIGNATURE<br><b>Robert C. La Mar</b>  |                              | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                       |  |
| EXAMINER'S NAME (Type)<br><b>ROBERT C. LA MAR, MD.D. 106 bay st Snow Hill, Md.</b>   |                              | 22. DATE SIGNED<br><b>8-2-67</b>  |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                              | 23b. DATE THEREOF<br><b>8/3/67</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PEHU BOTH</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>WHALEYVILLE Md</b>                            |  |
| 24. FUNERAL DIRECTOR<br><b>Anna R. Burbox Berlin Md</b>  |                              | ADDRESS   |  | 25a. REC'D BY REGISTRAR<br><b>AUG 7 1967</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

10328

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10328

|  |                               |  |                                      |
|--|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Worcester</u> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>             |                                      |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stockton</u>   |                               | c. LENGTH OF STAY IN 1b <u>4 Mons.</u>   |                                      |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hollond's Nursing Home</u>   |                               | d. STREET ADDRESS <u>2311</u>  |                                      |
| 3. NAME OF DECEASED (Type or print) <u>ANNIE P. MASON</u>  |                               | 4. DATE OF DEATH <u>July 13, 1967</u>  |                                      |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan 31, 1886</u> |
| 9. AGE (In years last birthday) <u>81</u> yrs.   |                               | IF UNDER 1 YEAR <u>Months</u> Days <u>Hours</u> Min.   |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during usual of working life, even if retired) <u>StoreKeeper</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>   |                                      |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Worcester, Maryland</u>   |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |                                      |
| 13. FATHER'S NAME <u>Silas Payne</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>Roberta Townsend</u>   |                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>  |                               | 16. SOCIAL SECURITY NO. <u>219-05-7351</u>   |                                      |
| 17. INFORMANT <u>Mrs. Louise Tarr, Snow Hill, Md.</u>  |                               | Address  |                                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>43200</u> <u>Congestive Heart failure</u><br>DUE TO (b) <u>Arteriosclerotic Heart-</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Disease</u> |                               | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u><br><u>Years</u>   |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                      |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>  |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work   |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                      |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>61</u> , to <u>July</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>July 7</u> 19 <u>67</u> , and that death occurred at <u>7</u> M, from causes and on the date stated above.   |                               |  |                                      |
| 22a. SIGNATURE <u>David Rafat</u>  |                               | 22b. DATE SIGNED <u>7/13/67</u>  |                                      |
| 22c. PHYSICIAN'S NAME (Type) <u>David Rafat MD</u>   |                               | 22d. ADDRESS <u>Snow Hill, Maryland</u>  |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                               | 23b. DATE THEREOF <u>7/15/1967</u>   |                                      |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Methodist Cem.</u>   |                               | 23d. LOCATION (City or Town) (County) (State) <u>Stockton, Md.</u>   |                                      |
| 24. FUNERAL DIRECTOR <u>Charles Judge</u>  |                               | 25a. REC'D BY REGISTRAR <u>JUL 18 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>   |                                      |
| DATE <u>Snow Hill, Md.</u>   |                               | DATE   |                                      |

10038

CERTIFICATE OF DEATH

George W. Lee  
Age 3 years  
Born [illegible]  
Died [illegible]

John & Co

July 1

July 1

JUL 13 1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> <div> <p>10329</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH<br/>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> </div> <div> <p>11746</p> </div> </div> <p style="text-align: center;"><b>CERTIFICATE OF DEATH</b></p> |  |  |  |   |  |  |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|--|--|
| <p>1. PLACE OF DEATH<br/>a. COUNTY <u>Worcester</u> MARYLAND</p>  |  |  |  |   |  | <p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br/>a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u></p> |  |  |  |  |  |
| <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br/><u>Bishopville</u></p>  |  |  |  | <p>c. LENGTH OF STAY IN 1b</p>  |  | <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br/><u>Bishopville</u></p>                                       |  |  |  |  |  |
| <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)</p>   |  |  |  |   |  | <p>d. STREET ADDRESS</p>   |  |  |  |  |  |
| <p>3. NAME OF DECEASED (Type or print) First Middle Last<br/><u>Clarence Alfred Melson</u></p>  |  |  |  |   |  | <p>4. DATE OF DEATH Month Day Year<br/><u>7 29 19 67</u></p>   |  |  |  |  |  |
| <p>5. SEX<br/><u>M</u></p>  |  | <p>6. COLOR OR RACE<br/><u>White</u></p> |  | <p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br/>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p> |  | <p>8. DATE OF BIRTH<br/><u>11/15/1905</u></p>  |  | <p>9. AGE (In years last birthday)<br/><u>61</u> yrs.</p>                            |  | <p>IF UNDER 1 YEAR: Months Days Hours Min.<br/><u>23 1</u></p> |  |
| <p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br/><u>Poultryman</u></p>  |  |  |  | <p>10b. KIND OF BUSINESS OR INDUSTRY<br/><u>Poultry</u></p>   |  | <p>11. BIRTHPLACE (County &amp; State, or foreign country)<br/><u>Maryland</u></p>   |  |  | <p>12. CITIZEN OF WHAT COUNTRY?<br/><u>USA</u></p>                                   |  |  |
| <p>13. FATHER'S NAME<br/><u>L. Alfred Melson</u></p>  |  |  |  |   |  | <p>14. MOTHER'S MAIDEN NAME<br/><u>Elizabeth Melson</u></p>  |  |  |  |  |  |
| <p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br/><u>Yes</u></p>   |  |  |  | <p>16. SOCIAL SECURITY NO.<br/><u>World War II 219-07-1934</u></p>  |  | <p>17. INFORMANT<br/><u>Grace Melson (Wife)</u></p>  |  |  | <p>Address<br/><u>Bishopville</u></p>  |  |  |
| <p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br/>PART I. DEATH WAS CAUSED BY:<br/>IMMEDIATE CAUSE (a) <u>myocardial infarction</u><br/>4201 DUE TO (b) <u>coronary atherosclerosis</u><br/>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)</p>      |  |  |  |   |  |  |  |  |  |  |  |
| <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br/><u>None</u></p>  |  |  |  |   |  |  |  |  |  |  |  |
| <p>19. WAS AUTOPSY PERFORMED?<br/>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>   |  |  |  |   |  |  |  |  |  |  |  |
| <p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>   |  |  |  | <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>   |  |  |  |  |  |  |  |
| <p>20c. TIME OF INJURY Month, Day, Year<br/>Hour a.m. p.m. <u>19</u></p>  |  |  |  | <p>20d. INJURY OCCURRED<br/>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>   |  | <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>  |  | <p>20f. (City or town) (County) (State)<br/><u>Mar. 2, 1964 to July 29, 1967</u></p> |  |  |  |
| <p>21. I certify that (I) (this hospital) attended the deceased from <u>Mar. 2, 1964</u> to <u>July 29, 1967</u>, that (I) (we) last saw the deceased alive on <u>Apr. 23, 1967</u>, and that death occurred at <u>3P</u> M, from the causes and on the date stated above.</p>  |  |  |  |   |  |  |  |  |  |  |  |
| <p>22a. SIGNATURE<br/><u>Jack C. Lewis</u></p>  |  |  |  |   |  | <p>22b. DATE SIGNED<br/><u>Aug. 12, '67</u></p>  |  |  | <p>22c. PHYSICIAN'S NAME (Type)<br/><u>Jack C. Lewis, M. D.</u></p>                  |  |  |
| <p>22d. ADDRESS<br/><u>Selbyville, Delaware</u></p>   |  |  |  |   |  |  |  |  |  |  |  |
| <p>23a. BURIAL, CREMATION, REMOVAL (Specify)<br/><u>Burial</u></p>  |  |  |  | <p>23b. DATE THEREOF<br/><u>8/1/1967</u></p>  |  | <p>23c. NAME OF CEMETERY OR CREMATORY<br/><u>Odd Fellows Cemetery</u></p>  |  |  | <p>23d. LOCATION (City, town or county) (State)<br/><u>Bishopville, Maryland</u></p> |  |  |
| <p>24. FUNERAL DIRECTOR<br/><u>Alfred Melson, Frankford, Del.</u></p>   |  |  |  |   |  | <p>25a. REC'D BY REGISTRAR<br/><u>AUG 21 1967</u></p>  |  |  | <p>25b. REGISTRAR'S SIGNATURE<br/><u>Charles Judge</u></p>                           |  |  |

10828

CERTIFICATE OF DEATH

*Handwritten text, likely a signature or name, possibly "John" or "John A."*

*Handwritten mark or signature*

*Handwritten text, possibly a date or location, including "1901" and "New York"*

*Handwritten text at the bottom, possibly a date "AUG 1 1901" and a signature*

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10330

10329

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Worcester</u> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Md</u> b. COUNTY <u>WOR</u>                         |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin-Rural</u>   |                                  | c. LENGTH OF STAY IN Tb <u>1 hour</u>  |  |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishop-Rural</u>   |                                  | 23.1   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hickory Ridge Road</u>   |                                  | d. STREET ADDRESS <u>—</u>   |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>John Levin Mompford JR</u>  |                                  | 4. DATE OF DEATH <u>July 9 1967</u>  |  |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>N</u>        | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov 14, 1928</u>   |
| 9. AGE (In years, months, and days) <u>38</u> yrs.   |                                  | 10. IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>   |  |
| 11. BIRTHPLACE (State or foreign country) <u>Snow Hill, Md</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY <u>USA</u>   |  |
| 13. FATHER'S NAME <u>John Levin Mompford</u>   |                                  | 14. MOTHER'S MAIDEN NAME <u>Nancy Pitts</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>  |                                  | 16. SOCIAL SECURITY NO. <u>218-24-2587</u>   |  |
| 17. INFORMANT <u>Corp. SANDRAFFEE</u>  |                                  | Address <u>State blue Salisbury Md</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><u>981X</u> IMMEDIATE CAUSE (a) <u>GUN SHOT WOUND chest (long)</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>5 minutes</u><br>(c) <u>(APPROX)</u>  |                                  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>NONE</u>   |                                  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year <u>230 - July 9 1967</u>  |                                  | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Nat While <input type="checkbox"/> at work  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>   |                                  | 20f. (City or town) <u>Rural Berlin</u> (County) <u>WOR</u> (State) <u>Md</u>  |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |  |  |
| ACTUAL SIGNATURE <u>Richard T. Watson</u>  |                                  | 22. DATE SIGNED <u>July 12, 67</u>   |  |
| EXAMINER'S NAME (Type) <u>R. S. COWANSEN, JR</u>   |                                  | Address <u>Belleville, Del.</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>  | 23b. DATE THEREOF <u>7/13/67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Sarah Dukes Cem.</u>   | 23d. LOCATION (City or Town) <u>Bishop</u> (County) <u>WOR.</u> (State) <u>Md.</u> |
| 24. FUNERAL DIRECTOR <u>Richard T. Watson</u>  |                                  | 25a. REC'D BY REGISTRAR <u>JUL 19 1967</u>   |  |
| Address <u>Belleville, Del.</u>  |                                  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |  |

1. The first part of the paper is devoted to a general  
discussion of the problem. It is shown that the  
problem is of great importance and that it has  
not been completely solved. The author then  
presents a new method for solving the problem.  
This method is based on the use of the  
Fourier transform. It is shown that this  
method is very effective and that it can be  
applied to a wide range of problems.  
The author then discusses the results of his  
work and compares them with the results of  
other workers in the field. He concludes that  
his method is a significant improvement over  
the methods previously used.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VR A15ME 5  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10331

MARYLAND STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10330

|  |                                  |   |                                       |
|--|----------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Worcester</u> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>                          |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Snow Hill</u>   |                                  | c. LENGTH OF STAY IN 1b<br><u>23.1</u>  |                                       |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                       |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Jewell</u> Middle <u>B</u> Last <u>Northam</u>  |                                  | 4. DATE OF DEATH<br>Month <u>July</u> Day <u>27</u> Year <u>1967</u>  |                                       |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>           | 8. DATE OF BIRTH<br><u>Jan 7 1904</u> |
| 9. AGE (In years lost birthday) yrs. <u>63</u>   |                                  | 10. IF UNDER 1 YEAR<br>Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>   |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>  |                                       |
| 11. BIRTHPLACE (State or foreign country)<br><u>West Virginia</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |                                       |
| 13. FATHER'S NAME<br><u>Alexander Burge</u>  |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Alice Hatfield</u>   |                                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>None</u>  |                                       |
| 17. INFORMANT<br><u>S. Otis Northam, Snow Hill, Md.</u>  |                                  | Address   |                                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>DUE TO <u>4201</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ACUTE CORONARY OCCLUSION</u><br>DUE TO (c) <u>MINUTES</u>  |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>MINUTES</u>  |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                       |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                       |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m. <u>19</u>   |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not While <input type="checkbox"/> of work  |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |                                       |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |   |                                       |
| ACTUAL SIGNATURE <u>Robert C. La Mar</u> M.D.  |                                  | 22. DATE SIGNED <u>7/28/67</u>  |                                       |
| EXAMINER'S NAME (Type) <u>Robert C. La Mar, M. D., 104 Bay Street, Snow Hill, Md.</u>  |                                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |                                       |
| 23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>   |                                  | 23b. DATE THEREOF <u>July 29 1967</u>   |                                       |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Whitcomb Meth.</u>   |                                  | 23d. LOCATION (City or Town) (County) (State) <u>Snow Hill Md.</u>  |                                       |
| 24. FUNERAL DIRECTOR <u>Norman F. Hermin, Snow Hill, Md.</u>   |                                  | 25a. RECEIVED BY REGISTRAR <u>JUL 31 1967</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>   |                                       |

ARRESTED  
GARDIAN OCCASION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                           |   |   |  |   |                |   |  |
|---|--|---------------------------|---|---|--|---|----------------|---|--|
| 10332   |  |                           |   |   | 10331  |   |                |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY Worcester MARYLAND   |  |                           |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE Maryland b. COUNTY Worcester |   |                |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>St. Martins   |  |                           | c. LENGTH OF STAY IN 1b<br>Life           |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>St. Martins                                |   |                |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |  |                           |   |   | d. STREET ADDRESS<br>Berlin, Md. RFD   |   |                | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>Amanda Adkins Scott   |  |                           | First Middle Last                         |   | 4. DATE OF DEATH<br>July 28, 1967 19   |   | Month Day Year |   |  |
| 5. SEX<br>Female  |  | 6. COLOR OR RACE<br>White |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>Oct. 1, 1884                                |                | 9. AGE (In years last birthday)<br>82 yrs.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife  |  |                           |   | 10b. KIND OF BUSINESS OR INDUSTRY<br>Own Home   |  | 11. BIRTHPLACE (County & State, or foreign country)<br>Maryland |                | 12. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 13. FATHER'S NAME<br>Noah Adkins  |  |                           |   |   | 14. MOTHER'S MAIDEN NAME<br>Rittie Baker   |   |                |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)  |  |                           | 16. SOCIAL SECURITY NO.<br>213-18-4108-J1 |   | 17. INFORMANT<br>George Adkins Berlin, Md. RFD   |   | Address        |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Chronic Myocarditis<br>443X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension<br>DUE TO (c) Scleroderma<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>2Da. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>2Dc. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19<br>2Dd. KIND OF INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>2Df. (City or town) (County) (State)<br>21. I certify that (I) (this hospital) attended the deceased from 7-1-60, 19, to 7-28-67, that (I) (we) last saw the deceased alive on 7-10-67, and that death occurred at 5A.M. from the causes and on the date stated above.<br>22a. SIGNATURE<br>Clifford E. Scholtz<br>22b. DATE SIGNED<br>JUL 31 1967<br>22c. PHYSICIAN'S NAME (Type)<br>Clifford E. Scholtz MD<br>22d. ADDRESS<br>Berlin, Md.<br>23a. BURIAL, CREMATION, or other disposition<br>Burial Society<br>23b. DATE THEREOF<br>7/30/67<br>23c. NAME OF CEMETERY OR CREMATORY<br>Dale<br>23d. LOCATION (City, town or county) (State)<br>Whaleyville, Md.<br>24. FUNERAL DIRECTOR<br>Peter Whaley Selbyville, Del.<br>25a. REC'D BY REGISTRAR<br>JUL 31 1967<br>25b. REGISTRAR'S SIGNATURE<br>Charles Judge |  |                           |   |   |  |   |                |   |  |

1933

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10333

CERTIFICATE OF DEATH

10332

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Worcester</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Pocomoke</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Pocomoke</u> 23-1  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |   | d. STREET ADDRESS<br><u>209 Linden Ave.</u>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Joseph</u> Middle <u>Simpkins</u> Last <u>Simpkins</u>  |   | 4. DATE OF DEATH<br>Month <u>July</u> Day <u>7</u> Year <u>1967</u>   |  |
| 5. SEX<br><u>male</u>   | 6. COLOR OR RACE<br><u>negro</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Dec. 12 1895</u> 71 yrs.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Farm work</u>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>FLA.</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>Unknown</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>Unknown</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |   | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><u>Eva Wix Pocomoke, Md.</u>   |   | Address <u>209 Linden Ave.</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ACUTE CORONARY INFARCTION</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>LUETIC AORTIC INSUFFICIENCY</u><br>DUE TO<br>(c) <u>TETIARY LUES.</u> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>3-5 yrs.</u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>GEN. ART. SCLEROSIS.</u>   |   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10/24</u> , 19 <u>64</u> , to <u>7/7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10/24</u> , 19 <u>64</u> , and that death occurred at <u>11:30</u> A.M. from causes and on the date stated above.  |   |   |  |
| 22a. SIGNATURE<br><u>Neville A. Baron</u> M.D.  |   | 22b. DATE SIGNED<br><u>7/7/67</u>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>NEVILLE A. BARON</u>   |   | 22d. ADDRESS<br><u>Pocomoke, Md.</u>  |  |
| 23. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 23b. DATE THEREOF<br><u>7-10-67</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Olive Bapt. Cem.</u>   | 23d. LOCATION (City or Town) (County) (State)<br><u>Princess Anne Md.</u>                      |
| 24. FUNERAL DIRECTOR<br><u>Samuel S. Sauer</u>  |   | 25a. REC'D BY REGISTRAR<br><u>New Church, Va.</u> DATE <u>JUL 12 1967</u>   |  |
|   |   | 25b. REGISTRAR'S SIGNATURE<br><u>James Judge</u>  |  |

U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE  
OFFICE OF PUBLIC AFFAIRS

66301

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File, pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10334

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10333

|   |                           |   |                                  |   |   |   |  |
|---|---------------------------|---|----------------------------------|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Worcester</u> MARYLAND  |                           |   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Md</u> b. COUNTY <u>Anne Arundel</u> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Ocean City</u>   |                           | c. LENGTH OF STAY IN 1b<br><u>1 day</u>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Glen Burnie</u>                                    |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Stowaway Motel Parking lot.</u>  |                           |   |                                  | d. STREET ADDRESS<br><u>Glenwood Ave 409</u>  |   |   |  |
| 3. NAME OF DECEASED (Type or print) <u>Herbert Andrew STRAITZ</u>   |                           |   |                                  | 4. DATE OF DEATH <u>July 11 1967</u>  |   |   |  |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-30-26</u> | 9. AGE (In years lost birthday) <u>40</u> yrs.  | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS.<br>Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Number</u>  |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>USGvt.</u>  |                                  | 11. BIRTHPLACE (State or foreign country)<br><u>Baltimore, Md</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>Frederick G. STRAITZ</u>  |                           |   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>MARTHA E Schmidt</u>   |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>Yes Korea</u>   |                           | 16. SOCIAL SECURITY NO.<br><u>212-20-0235</u>   |                                  | 17. INFORMANT Address<br><u>MRS Gloria M STRAITZ wife.</u>  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4201 CORONARY Occlusion, Acute</u><br>DUE TO (b) <u>ASCVD -</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>UNKNOWN.</u>   |                           |   |                                  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>15 minutes</u>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>None</u>   |                           |   |                                  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                  |   |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <u>19</u>  |                           | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |                                  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                           |   |                                  |   |   |   |  |
| ACTUAL SIGNATURE<br><u>F S Townsend Jr</u>  |                           | EXAMINER'S NAME (Type)<br><u>F S Townsend Jr</u>  |                                  | M.D.<br><u>Ocean City, Md</u>   |   | 22. DATE SIGNED<br><u>7/11/67</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                           | 23b. DATE THEREOF<br><u>14 July 67</u>  |                                  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Baltimore National</u>   |   | 23d. LOCATION (City or Town) (County) (State)<br><u>Baltimore, Maryland</u>                       |  |
| 24. FUNERAL DIRECTOR<br><u>Kirkley Funeral Home, Glen Burnie, Md.</u>   |                           |   |                                  | 25a. REG'D BY REGISTRAR<br><u>JUL 13 1967</u>   |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>  |  |

1001  
A letter to  
George W. Bush  
from the National Endowment for the Arts  
dated April 11, 2001.  
The letter is addressed to George W. Bush  
at the White House, Washington, D.C.  
The letter discusses the National Endowment for the Arts  
and its role in supporting the arts.  
The letter is signed by the Director of the National Endowment for the Arts.  
The letter is dated April 11, 2001.

1002  
A letter to  
George W. Bush  
from the National Endowment for the Arts  
dated April 11, 2001.  
The letter is addressed to George W. Bush  
at the White House, Washington, D.C.  
The letter discusses the National Endowment for the Arts  
and its role in supporting the arts.  
The letter is signed by the Director of the National Endowment for the Arts.  
The letter is dated April 11, 2001.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10335

10334

|  |                                     |   |   |
|--|-------------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Worcester</b> <b>MARYLAND</b>  |                                     | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Pocomoke City</b>   | c. LENGTH OF STAY IN 1b             | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Wenona</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>819 Second St</b>   |                                     | d. STREET ADDRESS<br><b>Main Road</b>   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print) First <b>Sodia</b> Middle Last <b>Tawes</b>   |                                     | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>25</b> Year <b>1967</b>  |   |
| 5. SEX<br><b>F</b>   | 6. COLOR OR RACE<br><b>W</b>        | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 16, 1879</b>   |
| 9. AGE (In years last birthday)<br><b>88</b> yrs.  |                                     | IF UNDER 1 YEAR<br>Months <b>8</b> Days <b>25</b> Hours <b>10</b> Min.  | IF UNDER 24 HRS.<br>Hours <b>10</b> Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>  |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Household</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                      |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                     | 13. FATHER'S NAME<br><b>Alexander White</b>   |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Amanda White</b>  |                                     | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)                                      |   |
| 16. SOCIAL SECURITY NO.<br><b>None</b>   |                                     | 17. INFORMANT<br><b>Mrs Orville LaCurts</b> <b>819 Second St Pocomoke City MD</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br><b>331X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Arteriosclerosis</b> DUE TO<br>(c) |                                     | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 hours</b><br><b>years.</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arteriosclerosis. Degenerative Heart Disease</b>  |                                     | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. <b>19</b> p. m.   |                                     | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |
| 20f. (City or town)  |                                     | (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>Apr. 18, 1967</b> , to <b>July 25, 1967</b> , that I last saw the deceased alive on <b>July 25, 1967</b> , and that death occurred at <b>10:40 P.M.</b> from the causes and on the date stated above.   |                                     |   |   |
| ACTUAL SIGNATURE <b>Charles W. Trader</b>  |                                     | ADDRESS (Street, city or town, state) <b>302 Market Street, Pocomoke City, Maryland</b>   |   |
| PHYSICIAN'S NAME (Type) <b>Charles W. Trader, M.D.</b>   |                                     | DATE SIGNED <b>7-26-67</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>7/27/67</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St Johns Cemetery</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Deal Island Md</b>                            |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Leroy J. Webster</b>  |                                     | ADDRESS<br><b>Princess Anne MD</b>  |   |
| 24a. REC'D BY REGISTRAR<br><b>JUL 31 1967</b>  |                                     | 24b. REGISTRAR'S SIGNATURE<br><b>W. Clements Judge</b>  |   |

CERTIFICATE OF ANALYSIS

|                       |  |                       |  |
|-----------------------|--|-----------------------|--|
| Name of Sample        |  | Date of Analysis      |  |
| Name of Owner         |  | Name of Analyst       |  |
| Address of Owner      |  | Address of Analyst    |  |
| City and State        |  | City and State        |  |
| County                |  | County                |  |
| Zip Code              |  | Zip Code              |  |
| Description of Sample |  | Description of Sample |  |
| Amount of Sample      |  | Amount of Sample      |  |
| Date of Collection    |  | Date of Collection    |  |
| Method of Collection  |  | Method of Collection  |  |
| Method of Analysis    |  | Method of Analysis    |  |
| Results of Analysis   |  | Results of Analysis   |  |
| Signature of Analyst  |  | Signature of Analyst  |  |
| Date of Report        |  | Date of Report        |  |

FOR STATE HEALTH DEPT.

10336

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10325

|   |                              |   |  |  |   |  |  |
|---|------------------------------|---|--|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>WOR</u> MARYLAND  |                              |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>WOR</u> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>BERLIN</u>   |                              | c. LENGTH OF STAY IN 1b<br><u>50 years</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Berlin</u>                                |   |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Branch &amp; Snowell St</u>  |                              |   |  | d. STREET ADDRESS<br><u>Branch &amp; Snowell St</u>  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>EMMA Purnell Tingle</u>   |                              |   |  | 4. DATE OF DEATH Month Day Year<br><u>July 1 1967</u>  |   |  |  |
| 5. SEX<br><u>F</u>  | 6. COLOR OR RACE<br><u>N</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>July 26, 1882</u> | 9. AGE (In years and days)<br><u>80 yrs.</u>   | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><u></u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Berlin, MD</u>   |   | 12. CITIZEN OF WHAT COUNTRY<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>John James Purnell</u>  |                              |   |  | 14. MOTHER'S MAIDEN NAME<br><u>EMMA LINE Purnell</u>   |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |                              | 16. SOCIAL SECURITY NO.<br><u>217-54-5251</u>   |  | 17. INFORMANT Address<br><u>YANCIE Mumford, nephew, Berlin, MD</u>   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>570.2</u> DUE TO <u>Thrombosis, anterior mesenteric artery</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u><br>(c) <u></u> DUE TO <u></u>  |                              |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>Estimate 12-24 hours</u>                                |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                              |   |  |  |   | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |                              | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                              |   |  |  |   |  |  |
| ACTUAL SIGNATURE<br><u>F. J. Townsend, Jr.</u>  |                              | M.D.  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   | 22. DATE SIGNED<br><u>July 1, 1967</u>   |  |
| EXAMINER'S NAME (Type)<br><u>F. J. Townsend, Jr.</u>  |                              | ADDRESS (Street, city, town, or county)<br><u>Ocean City, MD</u>  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |                              | 23b. DATE THEREOF<br><u>7-6-67</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>New Bethel</u>  |   | 23d. LOCATION (City or town) (County) (State)<br><u>Berlin Wor. Md.</u>                        |  |
| 24. FUNERAL DIRECTOR<br><u>Loretta B. Jolley - Gray Rd #42</u>  |                              |   |  | 25a. REC'D BY REGISTRAR<br>DATE <u>JUL 7 1967</u>  |   | 25b. REGISTRAR'S SIGNATURE<br><u>J. Charles Judge</u>  |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10337

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

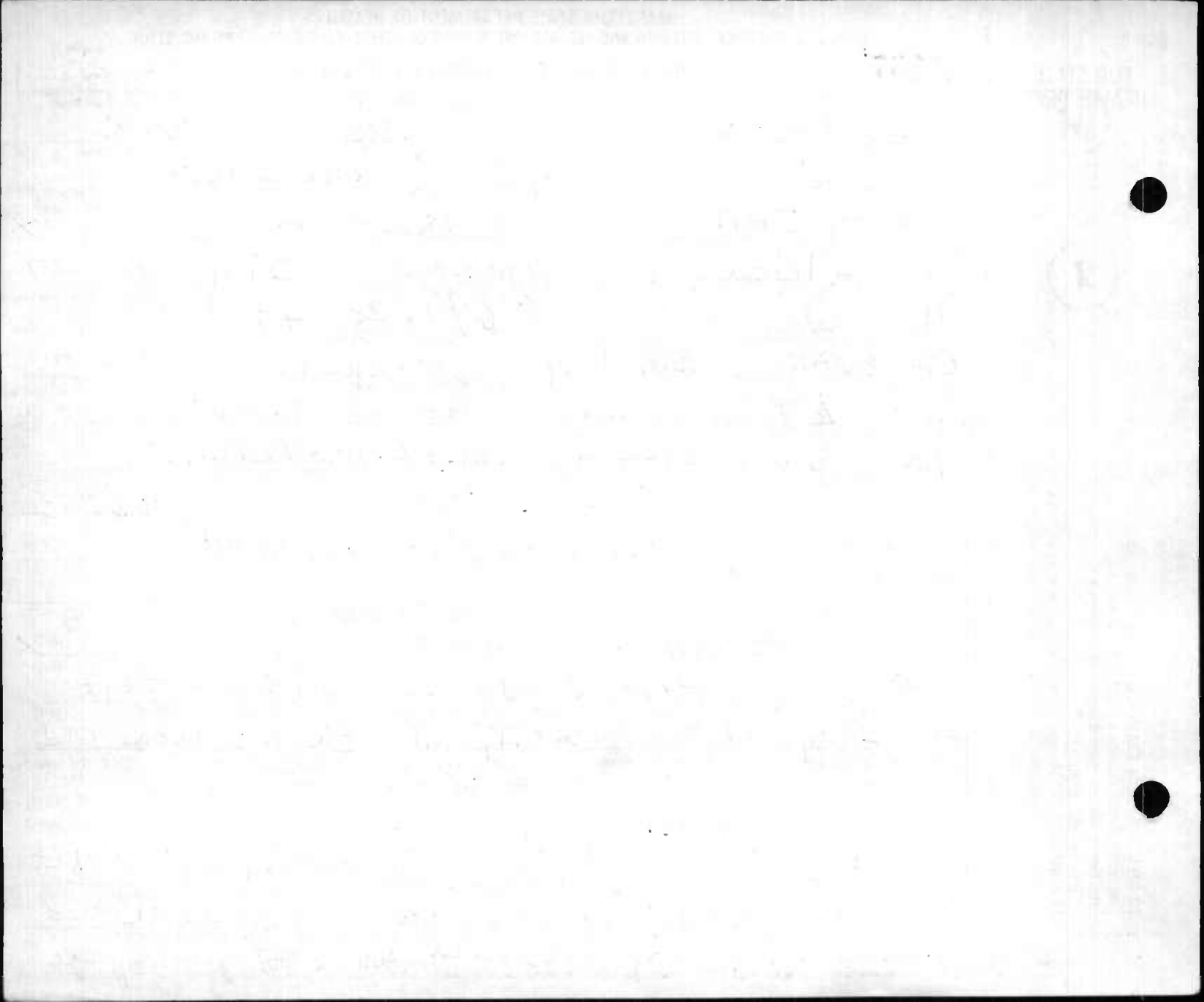
10336

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18, give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |                              |   |                                   |  |  |   |   |
|---|------------------------------|---|-----------------------------------|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Worcester</u> MARYLAND  |                              |   |                                   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>WOR</u> |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Berlin</u>   |                              | c. LENGTH OF STAY IN 1b<br><u>1 day</u>   |                                   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Berlin - RURAL</u>                        |  |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>City Jail</u>  |                              |   |                                   | d. STREET ADDRESS<br><u>Route 2</u>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Aldon</u> Middle <u>F.</u> Last <u>Townsend</u>   |                              |   |                                   | 4. DATE OF DEATH<br>Month <u>July</u> Day <u>22</u> Year <u>1967</u>   |  |   |   |
| 5. SEX<br><u>M</u>  | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>6/1/20</u> | 9. AGE (In years last birthday)<br><u>47</u> yrs.  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> |   | IF UNDER 24 HRS.<br>Hours <u>  </u> Min <u>  </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>CARPENTER</u>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Building</u>  |                                   | 11. BIRTHPLACE (State or foreign country)<br><u>MARYLAND</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |
| 13. FATHER'S NAME<br><u>Frederick T. Townsend</u>   |                              |   |                                   | 14. MOTHER'S MAIDEN NAME<br><u>Agnes Bradford</u>  |  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>Yes</u> <u>WW II</u>  |                              | 16. SOCIAL SECURITY NO.<br><u>216-14-9908</u>   |                                   | 17. INFORMANT<br><u>Berlin Police Dept Record,</u> Address <u>  </u>   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>SUFFOCATION</u><br>DUE TO <u>HANGING (self inflicted)</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>  </u><br>DUE TO <u>  </u><br>(c) <u>  </u>   |                              |   |                                   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>MINUTES</u>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Ethylism - Acute</u>  |                              |   |                                   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>Hanged self in cell with own Belt.</u>                   |                                   |  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br><u>330</u> Hour <u>a.m.</u> <u>July 22 1967</u>   |                              | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work   |                                   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>City Jail</u>                                       |  | 20f. (City or town) (County) (State)<br><u>Berlin WOR MD.</u>                                     |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                              |   |                                   |  |  |   |   |
| ACTUAL SIGNATURE<br><u>F.J. Townsend Jr.</u><br>EXAMINER'S NAME (Type)  |                              | M.D.  |                                   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  | 22. DATE SIGNED<br><u>July 22 1967</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                              | 23b. DATE THEREOF<br><u>7/26/67</u>   |                                   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Riverside</u>   |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Berlin WOR MD.</u>                            |   |
| 24. FUNERAL DIRECTOR<br><u>Anna A. Barbary Berlin Md</u> ADDRESS <u>  </u>  |                              |   |                                   | 25a. REC'D BY REGISTRAR<br>DATE <u>AUG 2 1967</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10338

CERTIFICATE OF DEATH

10337

|  |                               |  |                                   |
|--|-------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>WORCESTER</u> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>WICOMICO</u>                   |                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>   |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>  |                                   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)   |                               | d. STREET ADDRESS <u>123 2ND ST.</u>   |                                   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                               |  |                                   |
| 3. NAME OF DECEASED (Type or print) <u>MERVIN COLUMBUS WRIGHT SR.</u>  |                               | 4. DATE OF DEATH Month <u>7</u> Day <u>29</u> Year <u>1967</u>   |                                   |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-10-1907</u> |
| 9. AGE (In years last birthday) <u>60</u> yrs.   |                               | 10. IF UNDER 1 YEAR Months Days Hours Mm.  |                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY  |                                   |
| 11. BIRTHPLACE (County & State, or foreign country) <u>CHANCE, MD</u>  |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>  |                                   |
| 13. FATHER'S NAME <u>GEORGE WRIGHT SR.</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>HATTIE BIVENS</u>  |                                   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |                               | 16. SOCIAL SECURITY NO. <u>218-06-8850</u>   |                                   |
| 17. INFORMANT <u>EDNA WRIGHT</u>   |                               | Address <u>SALISBURY, MD</u>   |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4201 Coronary</u><br>DUE TO (b) <u>Chr Myocarditis</u><br>DUE TO (c) <u>last.</u>  |                               | INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>   |                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                   |
| 20c. TIME OF INJURY Month, Day, Year Hour 'a.m. p.m. <u>19</u>   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7-29</u> , 19 <u>67</u> , to <u>7-29</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-29</u> , 19 <u>67</u> , and that death occurred at <u>8:20</u> M, from causes and on the date stated above. |                               |  |                                   |
| 22a. SIGNATURE <u>Chas R. Law</u>  |                               | 22b. DATE SIGNED <u>7-31-67</u>  |                                   |
| 22c. PHYSICIAN'S NAME (Type) <u>Chas R. Law</u>  |                               | 22d. ADDRESS <u>Berlin Md</u>  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>  |                               | 23b. DATE THEREOF <u>8/2/67</u>  |                                   |
| 23c. NAME OF CEMETERY OR CREMATORY <u>McCalvary</u>  |                               | 23d. LOCATION (City or Town) (County) (State) <u>Fruitland Wicomico MD</u>   |                                   |
| 24. FUNERAL DIRECTOR <u>Hilda L West</u>   |                               | 25a. REC'D BY REGISTRAR <u>Aug 2 1967</u>  |                                   |
| ADDRESS <u>Naylor Mill Rd</u>  |                               | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |                                   |

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UNITED STATES DEPARTMENT OF AGRICULTURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10339

CERTIFICATE OF DEATH

10338

|   |                                       |  |   |   |  |   |   |  |
|---|---------------------------------------|--|---|---|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Worcester</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Pocomoke City</b><br>c. LENGTH OF STAY IN 1b<br><b>29 years</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>902 Cedar Street</b>   |                                       | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Worcester</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Pocomoke City</b><br>d. STREET ADDRESS<br><b>902 Cedar Street</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   |  |   |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>MARY</b><br>First<br><b>ELIZABETH</b><br>Middle<br><b>YOUNG</b><br>Last  |                                       | 4. DATE OF DEATH<br><b>July 17 1967</b><br>Month Day Year  |   |   |  |   |   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>      | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>Sept. 16, 1878</b> | 9. AGE (In years last birthday)<br><b>88</b> yrs.   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b> | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Delaware</b>                            | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |  |
| 13. FATHER'S NAME<br><b>James Larrimore</b>   |                                       | 14. MOTHER'S MAIDEN NAME<br><b>Martha Simmons</b>  |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b> |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |   | 17. INFORMANT<br><b>Edward W. Young, Pocomoke City, Md.</b><br>Address |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br>DUE TO (b) <b>Coronary Arteriosclerosis and Atherosclerosis</b><br>DUE TO (c) <b>and Atherosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><b>4201</b> |                                       |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>few min.</b>   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Carcinoma of Vagina</b>  |                                       |  |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                                       | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |   |  |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   |                                       | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>49</b> , to <b>May 15</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>May 15</b> , 19 <b>67</b> , and that death occurred at <b>7 P.M.</b> , from causes and on the date stated above.   |                                       |  |   |   |  |   |   |  |
| 22a. SIGNATURE<br><b>N.E. Sartorius, Jr.</b>  |                                       | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |   | 22b. DATE SIGNED<br><b>July 19, 1967</b>  |  |   |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>N.E. Sartorius, Jr., M.D.</b>  |                                       | 22d. ADDRESS<br><b>114 Market St., Pocomoke City, Md.</b>  |   |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>7-20-1967</b> | 23c. NAME OF CEMETERY OR CREMATOR<br><b>First Baptist</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Pocomoke - Worcester-Md.</b>  |  |   |   |  |
| 24. FUNERAL DIRECTOR<br><b>Robert H. Watson</b>   |                                       | ADDRESS<br><b>Pocomoke City, Md.</b>   |   | 25a. REC'D BY REGISTRAR<br><b>JUL 24 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |   |  |

50033

CHRONOLOGICAL INDEX

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

|      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      |      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|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|-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| 1917 | 1918 | 1919 | 1920 | 1921 | 1922 | 1923 | 1924 | 1925 | 1926 | 1927 | 1928 | 1929 | 1930 | 1931 | 1932 | 1933 | 1934 | 1935 | 1936 | 1937 | 1938 | 1939 | 1940 | 1941 | 1942 | 1943 | 1944 | 1945 | 1946 | 1947 | 1948 | 1949 | 1950 | 1951 | 1952 | 1953 | 1954 | 1955 | 1956 | 1957 | 1958 | 1959 | 1960 | 1961 | 1962 | 1963 | 1964 | 1965 | 1966 | 1967 | 1968 | 1969 | 1970 | 1971 | 1972 | 1973 | 1974 | 1975 | 1976 | 1977 | 1978 | 1979 | 1980 | 1981 | 1982 | 1983 | 1984 | 1985 | 1986 | 1987 | 1988 | 1989 | 1990 | 1991 | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2026 | 2027 | 2028 | 2029 | 2030 | 2031 | 2032 | 2033 | 2034 | 2035 | 2036 | 2037 | 2038 | 2039 | 2040 | 2041 | 2042 | 2043 | 2044 | 2045 | 2046 | 2047 | 2048 | 2049 | 2050 | 2051 | 2052 | 2053 | 2054 | 2055 | 2056 | 2057 | 2058 | 2059 | 2060 | 2061 | 2062 | 2063 | 2064 | 2065 | 2066 | 2067 | 2068 | 2069 | 2070 | 2071 | 2072 | 2073 | 2074 | 2075 | 2076 | 2077 | 2078 | 2079 | 2080 | 2081 | 2082 | 2083 | 2084 | 2085 | 2086 | 2087 | 2088 | 2089 | 2090 | 2091 | 2092 | 2093 | 2094 | 2095 | 2096 | 2097 | 2098 | 2099 | 2100 | 2101 | 2102 | 2103 | 2104 | 2105 | 2106 | 2107 | 2108 | 2109 | 2110 | 2111 | 2112 | 2113 | 2114 | 2115 | 2116 | 2117 | 2118 | 2119 | 2120 | 2121 | 2122 | 2123 | 2124 | 2125 | 2126 | 2127 | 2128 | 2129 | 2130 | 2131 | 2132 | 2133 | 2134 | 2135 | 2136 | 2137 | 2138 | 2139 | 2140 | 2141 | 2142 | 2143 | 2144 | 2145 | 2146 | 2147 | 2148 | 2149 | 2150 | 2151 | 2152 | 2153 | 2154 | 2155 | 2156 | 2157 | 2158 | 2159 | 2160 | 2161 | 2162 | 2163 | 2164 | 2165 | 2166 | 2167 | 2168 | 2169 | 2170 | 2171 | 2172 | 2173 | 2174 | 2175 | 2176 | 2177 | 2178 | 2179 | 2180 | 2181 | 2182 | 2183 | 2184 | 2185 | 2186 | 2187 | 2188 | 2189 | 2190 | 2191 | 2192 | 2193 | 2194 | 2195 | 2196 | 2197 | 2198 | 2199 | 2200 | 2201 | 2202 | 2203 | 2204 | 2205 | 2206 | 2207 | 2208 | 2209 | 2210 | 2211 | 2212 | 2213 | 2214 | 2215 | 2216 | 2217 | 2218 | 2219 | 2220 | 2221 | 2222 | 2223 | 2224 | 2225 | 2226 | 2227 | 2228 | 2229 | 2230 | 2231 | 2232 | 2233 | 2234 | 2235 | 2236 | 2237 | 2238 | 2239 | 2240 | 2241 | 2242 | 2243 | 2244 | 2245 | 2246 | 2247 | 2248 | 2249 | 2250 | 2251 | 2252 | 2253 | 2254 | 2255 | 2256 | 2257 | 2258 | 2259 | 2260 | 2261 | 2262 | 2263 | 2264 | 2265 | 2266 | 2267 | 2268 | 2269 | 2270 | 2271 | 2272 | 2273 | 2274 | 2275 | 2276 | 2277 | 2278 | 2279 | 2280 | 2281 | 2282 | 2283 | 2284 | 2285 | 2286 | 2287 | 2288 | 2289 | 2290 | 2291 | 2292 | 2293 | 2294 | 2295 | 2296 | 2297 | 2298 | 2299 | 2300 | 2301 | 2302 | 2303 | 2304 | 2305 | 2306 | 2307 | 2308 | 2309 | 2310 | 2311 | 2312 | 2313 | 2314 | 2315 | 2316 | 2317 | 2318 | 2319 | 2320 | 2321 | 2322 | 2323 | 2324 | 2325 | 2326 | 2327 | 2328 | 2329 | 2330 | 2331 | 2332 | 2333 | 2334 | 2335 | 2336 | 2337 | 2338 | 2339 | 2340 | 2341 | 2342 | 2343 | 2344 | 2345 | 2346 | 2347 | 2348 | 2349 | 2350 | 2351 | 2352 | 2353 | 2354 | 2355 | 2356 | 2357 | 2358 | 2359 | 2360 | 2361 | 2362 | 2363 | 2364 | 2365 | 2366 | 2367 | 2368 | 2369 | 2370 | 2371 | 2372 | 2373 | 2374 | 2375 | 2376 | 2377 | 2378 | 2379 | 2380 | 2381 | 2382 | 2383 | 2384 | 2385 | 2386 | 2387 | 2388 | 2389 | 2390 | 2391 | 2392 | 2393 | 2394 | 2395 | 2396 | 2397 | 2398 | 2399 | 2400 | 2401 | 2402 | 2403 | 2404 | 2405 | 2406 | 2407 | 2408 | 2409 | 2410 | 2411 | 2412 | 2413 | 2414 | 2415 | 2416 | 2417 | 2418 | 2419 | 2420 | 2421 | 2422 | 2423 | 2424 | 2425 | 2426 | 2427 | 2428 | 2429 | 2430 | 2431 | 2432 | 2433 | 2434 | 2435 | 2436 | 2437 | 2438 | 2439 | 2440 | 2441 | 2442 | 2443 | 2444 | 2445 | 2446 | 2447 | 2448 | 2449 | 2450 | 2451 | 2452 | 2453 | 2454 | 2455 | 2456 | 2457 | 2458 | 2459 | 2460 | 2461 | 2462 | 2463 | 2464 | 2465 | 2466 | 2467 | 2468 | 2469 | 2470 | 2471 | 2472 | 2473 | 2474 | 2475 | 2476 | 2477 | 2478 | 2479 | 2480 | 2481 | 2482 | 2483 | 2484 | 2485 | 2486 | 2487 | 2488 | 2489 | 2490 | 2491 | 2492 | 2493 | 2494 | 2495 | 2496 | 2497 | 2498 | 2499 | 2500 | 2501 | 2502 | 2503 | 2504 | 2505 | 2506 | 2507 | 2508 | 2509 | 2510 | 2511 | 2512 | 2513 | 2514 | 2515 | 2516 | 2517 | 2518 | 2519 | 2520 | 2521 | 2522 | 2523 | 2524 | 2525 | 2526 | 2527 | 2528 | 2529 | 2530 | 2531 | 2532 | 2533 | 2534 | 2535 | 2536 | 2537 | 2538 | 2539 | 2540 | 2541 | 2542 | 2543 | 2544 | 2545 | 2546 | 2547 | 2548 | 2549 | 2550 | 2551 | 2552 | 2553 | 2554 | 2555 | 2556 | 2557 | 2558 | 2559 | 2560 | 2561 | 2562 | 2563 | 2564 | 2565 | 2566 | 2567 | 2568 | 2569 | 2570 | 2571 | 2572 | 2573 | 2574 | 2575 | 2576 | 2577 | 2578 | 2579 | 2580 | 2581 | 2582 | 2583 | 2584 | 2585 | 2586 | 2587 | 2588 | 2589 | 2590 | 2591 | 2592 | 2593 | 2594 | 2595 | 2596 | 2597 | 2598 | 2599 | 2600 | 2601 | 2602 | 2603 | 2604 | 2605 | 2606 | 2607 | 2608 | 2609 | 2610 | 2611 | 2612 | 2613 | 2614 | 2615 | 2616 | 2617 | 2618 | 2619 | 2620 | 2621 | 2622 | 2623 | 2624 | 2625 | 2626 | 2627 | 2628 | 2629 | 2630 | 2631 | 2632 | 2633 | 2634 | 2635 | 2636 | 2637 | 2638 | 2639 | 2640 | 2641 | 2642 | 2643 | 2644 | 2645 | 2646 | 2647 | 2648 | 2649 | 2650 | 2651 | 2652 | 2653 | 2654 | 2655 | 2656 | 2657 | 2658 | 2659 | 2660 | 2661 | 2662 | 2663 | 2664 | 2665 | 2666 | 2667 | 2668 | 2669 | 2670 | 2671 | 2672 | 2673 | 2674 | 2675 | 2676 | 2677 | 2678 | 2679 | 2680 | 2681 | 2682 | 2683 | 2684 | 2685 | 2686 | 2687 | 2688 | 2689 | 2690 | 2691 | 2692 | 2693 | 2694 | 2695 | 2696 | 2697 | 2698 | 2699 | 2700 | 2701 | 2702 | 2703 | 2704 | 2705 | 2706 | 2707 | 2708 | 2709 | 2710 | 2711 | 2712 | 2713 | 2714 | 2715 | 2716 | 2717 | 2718 | 2719 | 2720 | 2721 | 2722 | 2723 | 2724 | 2725 | 2726 | 2727 | 2728 | 2729 | 2730 | 2731 | 2732 | 2733 | 2734 | 2735 | 2736 | 2737 | 2738 | 2739 | 2740 | 2741 | 2742 | 2743 | 2744 | 2745 | 2746 | 2747 | 2748 | 2749 | 2750 | 2751 | 2752 | 2753 | 2754 | 2755 | 2756 | 2757 | 2758 | 2759 | 2760 | 2761 | 2762 | 2763 | 2764 | 2765 | 2766 | 2767 | 2768 | 2769 | 2770 | 2771 | 2772 | 2773 | 2774 | 2775 | 2776 | 2777 | 2778 | 2779 | 2780 | 2781 | 2782 | 2783 | 2784 | 2785 | 2786 | 2787 | 2788 | 2789 | 2790 | 2791 | 2792 | 2793 | 2794 | 2795 | 2796 | 2797 | 2798 | 2799 | 2800 | 2801 | 2802 | 2803 | 2804 | 2805 | 2806 | 2807 | 2808 | 2809 | 2810 | 2811 | 2812 | 2813 | 2814 | 2815 | 2816 | 2817 | 2818 | 2819 | 2820 | 2821 | 2822 | 2823 | 2824 | 2825 | 2826 | 2827 | 2828 | 2829 | 2830 | 2831 | 2832 | 2833 | 2834 | 2835 | 2836 | 2837 | 2838 | 2839 | 2840 | 2841 | 2842 | 2843 | 2844 | 2845 | 2846 | 2847 | 2848 | 2849 | 2850 | 2851 | 2852 | 2853 | 2854 | 2855 | 2856 | 2857 | 2858 | 2859 | 2860 | 2861 | 2862 | 2863 | 2864 | 2865 | 2866 | 2867 | 2868 | 2869 | 2870 | 2871 | 2872 | 2873 | 2874 | 2875 | 2876 | 2877 | 2878 | 2879 | 2880 | 2881 | 2882 | 2883 | 2884 | 2885 | 2886 | 2887 | 2888 | 2889 | 2890 | 2891 | 2892 | 2893 | 2894 | 2895 | 2896 | 2897 | 2898 | 2899 | 2900 | 2901 | 2902 | 2903 | 2904 | 2905 | 2906 | 2907 | 2908 | 2909 | 2910 | 2911 | 2912 | 2913 | 2914 | 2915 | 2916 | 2917 | 2918 | 2919 | 2920 | 2921 | 2922 | 2923 | 2924 | 2925 | 2926 | 2927 | 2928 | 2929 | 2930 | 2931 | 2932 | 2933 | 2934 | 2935 | 2936 | 2937 | 2938 | 2939 | 2940 | 2941 | 2942 | 2943 | 2944 | 2945 | 2946 | 2947 | 2948 | 2949 | 2950 | 2951 | 2952 | 2953 | 2954 | 2955 | 2956 | 2957 | 2958 | 2959 | 2960 | 2961 | 2962 | 2963 | 2964 | 2965 | 2966 | 2967 | 2968 | 2969 | 2970 | 2971 | 2972 | 2973 | 2974 | 2975 | 2976 | 2977 | 2978 | 2979 | 2980 | 2981 | 2982 | 2983 | 2984 | 2985 | 2986 | 2987 | 2988 | 2989 | 2990 | 2991 | 2992 | 2993 | 2994 | 2995 | 2996 | 2997 | 2998 | 2999 | 3000 | 3001 | 3002 | 3003 | 3004 | 3005 | 3006 | 3007 | 3008 | 3009 | 3010 | 3011 | 3012 | 3013 | 3014 | 3015 | 3016 | 3017 | 3018 | 3019 | 3020 | 3021 | 3022 | 3023 | 3024 | 3025 | 3026 | 3027 | 3028 | 3029 | 3030 | 3031 | 3032 | 3033 | 3034 | 3035 | 3036 | 3037 | 3038 | 3039 | 3040 | 3041 | 3042 | 3043 | 3044 | 3045 | 3046 | 3047 | 3048 | 3049 | 3050 | 3051 | 3052 | 3053 | 3054 | 3055 | 3056 | 3057 | 3058 | 3059 | 3060 | 3061 | 3062 | 3063 | 3064 | 3065 | 3066 | 3067 | 3068 | 3069 | 3070 | 3071 | 3072 | 3073 | 3074 | 3075 | 3076 | 3077 | 3078 | 3079 | 3080 | 3081 | 3082 | 3083 | 3084 | 3085 | 3086 | 3087 | 3088 | 3089 | 3090 | 3091 | 3092 | 3093 | 3094 | 3095 | 3096 | 3097 | 3098 | 3099 | 3100 | 3101 | 3102 | 3103 | 3104 | 3105 | 3106 | 3107 | 3108 | 3109 | 3110 | 3111 | 3112 | 3113 | 3114 | 3115 | 3116 | 3117 | 3118 | 3119 | 3120 | 3121 | 3122 | 3123 | 3124 | 3125 | 3126 | 3127 | 3128 | 3129 | 3130 | 3131 | 3132 | 3133 | 3134 | 3135 | 3136 | 3137 | 3138 | 3139 | 3140 | 3141 | 3142 | 3143 | 3144 | 3145 | 3146 | 3147 | 3148 | 3149 | 3150 | 3151 | 3152 | 3153 | 3154 | 3155 | 3156 | 3157 | 3158 | 3159 | 3160 | 3161 | 3162 | 3163 | 3164 | 3165 | 3166 | 3167 | 3168 | 3169 | 3170 | 3171 | 3172 | 3173 | 3174 | 3175 | 3176 | 3177 | 3178 | 3179 | 3180 | 3181 | 3182 | 3183 | 3184 | 3185 | 3186 | 3187 | 3188 | 3189 | 3190 | 3191 | 3192 | 3193 | 3194 | 3195 | 3196 | 3197 | 3198 | 3199 | 3200 | 3201 | 3202 | 3203 | 3204 | 3205 | 3206 | 3207 | 3208 | 3209 | 3210 | 3211 | 3212 | 3213 | 3214 | 3215 | 3216 | 3217 | 3218 | 3219 | 3220 | 3221 | 3222 | 3223 | 3224 | 3225 | 3226 | 3227 | 3228 | 3229 | 3230 | 3231 | 3232 | 3233 | 3234 | 3235 | 3236 | 3237 | 3238 | 3239 | 3240 | 3241 | 3242 | 3243 | 3244 | 3245 | 3246 | 3247 | 3248 | 3249 | 3250 | 3251 | 3252 | 3253 | 3254 | 3255 | 3256 | 3257 | 3258 | 3259 | 3260 | 3261 | 3262 | 3263 | 3264 | 3265 | 3266 | 3267 | 3268 | 3269 | 3270 | 3271 | 3272 | 3273 | 3274 | 3275 | 3276 |
|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|------|-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